SERFF Tracking Number: HUMA-127883199 State: Arkansas Filing Company: State Tracking Number: 50496 Humana Dental Insurance Company

Company Tracking Number: AR-11-009

TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental

Product Name: AR App Maint - HDIC Project Name/Number: Apps Update/PC-114

Filing at a Glance

Company: Humana Dental Insurance Company

Product Name: AR App Maint - HDIC SERFF Tr Num: HUMA-127883199 State: Arkansas

TOI: H10G Group Health - Dental SERFF Status: Closed-Approved State Tr Num: 50496

Sub-TOI: H10G.000 Health - Dental Co Tr Num: AR-11-009 State Status: Approved-Closed

> Author: Wendy Jeffries Disposition Date: 12/20/2011

> > Deemer Date:

Reviewer(s): Donna Lambert

Date Submitted: 12/16/2011 Disposition Status: Approved Implementation Date: 01/20/2012

Implementation Date Requested: On Approval

State Filing Description:

Filing Type: Form

General Information

Project Name: Apps Update Status of Filing in Domicile: Not Filed

Project Number: PC-114 Date Approved in Domicile: Requested Filing Mode: Review & Approval Domicile Status Comments: na

Explanation for Combination/Other: Market Type: Group

Group Market Size: Small and Large Submission Type: New Submission

Group Market Type: Employer Overall Rate Impact:

Filing Status Changed: 12/20/2011

State Status Changed: 12/20/2011

Created By: Wendy Jeffries Submitted By: Wendy Jeffries

Corresponding Filing Tracking Number:

Filing Description:

This is a new filing; the attached forms do not replace or supersede any like forms previously filed. These forms are for use in the group market. These forms are being filed for general use with all approved policy series and may be offered in a printed, online, or digitized audio recorded format.

This application will be used to support our currently marketed products in your state. The changes in the application reflect cosmetic changes in format, design and language. These changes are intended to create a more consumer friendly application form for our future applicants to assist them in understanding the application process. Included with this submission are the following documents:

- Certificate of Readability; and
- -Filing Fee of \$200 (\$50 per form).

Company Tracking Number: AR-11-009

TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental

Product Name: AR App Maint - HDIC
Project Name/Number: Apps Update/PC-114

To the best of our knowledge, we believe the attached forms satisfy the minimum requirements of applicable Arkansas statutes and regulations.

If you have any questions regarding this filing, please contact me by phone at (800) 664-4140, extension 1783 or by e-mail at wjeffries@humana.com.

Company and Contact

Filing Contact Information

Wendy Jeffries, Regional Contract Analyst wjeffries@humana.com 321 W. Main Street 502-580-1783 [Phone]

6th Floor, East Tower Louisville, KY 40202

Filing Company Information

Humana Dental Insurance Company CoCode: 70580 State of Domicile: Wisconsin

1100 Employer's Blvd Group Code: 119 Company Type:
Green Bay, WI 54344 Group Name: State ID Number:

(800) 558-4444 ext. [Phone] FEIN Number: 39-0714280

Filing Fees

Fee Required? Yes Fee Amount: \$200.00

Retaliatory? No

Fee Explanation: 4 forms x \$50 equals \$200.00

Per Company: No

COMPANY AMOUNT DATE PROCESSED TRANSACTION #

Humana Dental Insurance Company \$200.00 12/16/2011 54594660

Company Tracking Number: AR-11-009

TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental

Product Name: AR App Maint - HDIC
Project Name/Number: Apps Update/PC-114

Correspondence Summary

Dispositions

Status Created By Created On Date Submitted

Approved Donna Lambert 12/20/2011 12/20/2011

Objection Letters and Response Letters

Objection Letters Response Letters

Status Created By Created On Date Submitted Responded By Created On Date Submitted

Pending Donna 12/20/2011 12/20/2011 Wendy Jeffries 12/20/2011 12/20/2011

Industry Lambert

Response

Company Tracking Number: AR-11-009

TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental

Product Name: AR App Maint - HDIC
Project Name/Number: Apps Update/PC-114

Disposition

Disposition Date: 12/20/2011 Implementation Date: 01/20/2012

Status: Approved

Comment:

Rate data does NOT apply to filing.

Company Tracking Number: AR-11-009

TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental

Product Name: AR App Maint - HDIC
Project Name/Number: Apps Update/PC-114

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved	Yes
Supporting Document	Application	Approved	Yes
Supporting Document	Statement of Variability	Approved	Yes
Form	100+ Employer Group Application	Approved	Yes
Form	2-99 Employer Group Application	Approved	Yes
Form	Group Employee and Individual App and	Approved	Yes
	Enrollment form 2-99 Employees		
Form	Large Group Employee and Individual	Approved	Yes
	App and Enrollment form		

Company Tracking Number: AR-11-009

TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental

Product Name: AR App Maint - HDIC
Project Name/Number: Apps Update/PC-114

Objection Letter

Objection Letter Status Pending Industry Response

Objection Letter Date 12/20/2011
Submitted Date 12/20/2011
Respond By Date 01/20/2012

Dear Wendy Jeffries,

This will acknowledge receipt of the captioned filing.

The Filing Description states that these forms do not replace any previously approved forms, then states, "The changes in the application reflect cosmetic changes in format, design and language." What language has been changed?

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

Please feel free to contact me if you have guestions.

Sincerely,

Donna Lambert

Company Tracking Number: AR-11-009

TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental

Product Name: AR App Maint - HDIC
Project Name/Number: Apps Update/PC-114

Response Letter

Response Letter Status Submitted to State

Response Letter Date 12/20/2011 Submitted Date 12/20/2011

Dear Donna Lambert,

Comments:

Response 1

Comments: The biggest alteration was that we have combined all of our lines of business into one form so we have taken elements from previous filed forms and added them to this single form for agent and group convenience.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Sincerely,

Wendy Jeffries

Company Tracking Number: AR-11-009

TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental

Product Name: AR App Maint - HDIC
Project Name/Number: Apps Update/PC-114

Form Schedule

Lead Form Number:

Schedule	Form	Form Type Form Name	Action	Action Specific	Readability	Attachment
Item	Number			Data		
Status						
Approved	AR-71012-	Application/100+ Employer	Initial			AR-71012-
12/20/2011	EA-LG	Enrollment Group Application				EA-LG-
	20111114	Form				20111114.pdf
Approved	AR-71012-	Application/2-99 Employer Grou	pInitial			AR-71012-
12/20/2011	EA-SB	Enrollment Application				EA-SB-
	20111114	Form				20111114.pdf
Approved	AR-72000	Application/Group Employee and	d Initial			AR-72000-
12/20/2011	20111103	Enrollment Individual App and				20111114.pdf
		Form Enrollment form 2-99	9			
		Employees				
Approved	AR-72001	Application/Large Group	Initial			AR-72001-
12/20/2011	20111114	Enrollment Employee and				20111114.pdf
		Form Individual App and				
		Enrollment form				

[100+] Employer/Group Application - Arkansas



FOR GROUP COVERAGE (100+ ELIGIBLE EMPLOYEES)

Humana.com

The offering company(ies) listed below, severally or collectively, as the content may require, are referred to in the Large Group/Employer Application as "Humana".

[Medical plans insured or administered by Humana Insurance Company.] [Dental plans insured or administered by [HumanaDental Insurance Company] [or] [Humana Insurance Company] [or] [CompBenefits Insurance Company].] [Dental HMO plans offered by American Dental Providers of Arkansas, Inc.] (Vision plans insured or administered by [Humana Insurance Company] [or] [CompBenefits Insurance Company].] [[Group Critical Illness], [Short Term Disability], [Long Term Disability] [and] [Workplace Voluntary] plans insured by Kanawha Insurance Company.] [Life plans insured or administered by [Humana Insurance Company] [or] [Kanawha Insurance Company].]

[1-10]. EMPLOYER COMPANY INFORM	IATION:	Please type	or print clear	ly in black i	ink Interr	nal use only	Group i	number:	
Full legal business name					·			Requested e	ffective date
Corporate/Situs location street address (P.O. Box r	not allowe	d) City			State	ZIP code		County	
	☐ Sole Pr ☐ Other (oprietorship (explain))	Date co	mpany e	stablished	Feder	al Tax ID	
Nature of business/SIC code	Busii (ness phone)	number			Business far	x numb	er	
Do you have more than one location? ☐ No	□ Ye	S							
Benefit Administrator/Management contact	t name:								
Phone number ()	Fax numb (er)			E-	·mail			
Management contact: Mother's maiden name (this will be used to gain access to the Employer S	Self-Servic	e Center on	www.Hum	ana.com)					
Billing contact name:									
Billing address (N/A, if same as street address)				City				State	ZIP code
Phone number ()	Fax numb (er)			E-	mail			
[Are separate divisions/classes required for billing attach an additional page. Each additional page r				If yes, pl	ease exp	lain. If additi	onal sp	ace is neede	ed, please
[For Workplace Voluntary Benefits: Effective	date of po	licy and du	e date of fir	st premiur	n will be	(month, day	, year) _	//]
[Type of Billing: □ Self Billed □ Listed Billed	Prem	ium mode	: □ Month	ly 🗆 Quá	arterly \Box	l Semi-Annua	al 🗆 Ai	nnual]	
[1-10]. ELIGIBILITY REQUIREMENTS Number of employees on payroll An working at least the number of hours per week as	n employe indicated	e who is eli in the table	gible to app below.	oly for insu	ırance is	one who is a	ctively	at work on	a full-time basis
	[All	[Medical	[Dental	[Life	[Vision	[STD	[LTD	[Group Critical Illness	
A. Number of hours worked per week to be eligible (select between 20 and 40 hours)									
B. Number of employees in a probationary waiting period (do not include in the eligible count below in C)									
C. Total number of eligible employees									
Number of employees:									
waiving with other qualifying coverage									
waiving without other qualifying coverage				_					
Number of employees to be enrolled]]]]]]]]]]
Probationary waiting period for eligible employee (if you prefer months, please select "Other" and s	pecify the	number of		□ 60 da	<u>, </u>	□ 90 days		ther (specify	
Employee effective provision: [(On all plans, excep STD/LTD is immediate.)] [New	y waiting	period	☐ Imm	nediately fo	ollowing	cides with th probationary probationary	/ waitin	g period]	vision.

[1-10]. ELIGIBILITY REQU							
Do you want to exclude a class of the second of the secon	ptions vary by pla	an. Refer to the I	Jnderwrit ∃ non-ma	ing Require nagement	ements for each pl ☐ other:		_
Employee Eligibility by Clas According to Federal health care may result in a penalty. To avoic plan does not favor highly comp	e reform, an emp d penalties, pleas	e review any cla	ss-based	benefits wi	th your legal or fin		
Has this group been insured by If yes, please provide prior group			rs?	□ No □ Ye	es		
Is this a Collectively Bargained F	Plan? □ No	☐ Yes Nam	e of Plan		//		(iii IDC (FEOO)
Plan number Do you wish to offer Domestic P	Partner Coverage	2	 Π γ _Δ ς		(Assigned by	Employer for use in	n filing IRS form 5500)
Retiree information	artifer Coverage		☐ 162				
For groups 26+, are you offering	g coverage to reti	rees? No	☐ Yes	If yes, rec	quired age	_ Minimum ye	ars of service
		All		dical	Dental	Vision	Life (if applicable)
Number of current retirees to b	e covered						
Does this company have any sultax return? ☐ No ☐ Yes If yes			any othe	er associate	ed entities that are	eligible to file a fe	deral or state combined
Company name							Total employees
[Group Term Life,] [Short Ter	rm Disability,] [Long Term Dis	ability,]	and [Grou	up Critical Illnes	s] only	
Effective dates for changes					lay of month fol		Other
Increases/decreases due to cha							
III marcases accidases due to cito							
Increases/decreases requested	by employee						
		ed by employee					
Increases/decreases requested		ed by employee					
Increases/decreases requested Increases (with Evidence of Ins	urability) request	, , ,	or exceeds	amounts b			
Increases/decreases requested Increases (with Evidence of Ins Decreases due to age	urability) request	, , ,		amounts b		Class 1	Class 2
Increases/decreases requested Increases (with Evidence of Ins Decreases due to age Evidence of Insurability required Employee life	if amount of cov Class 1	erage applied fo	2 Sp	ouse life	pelow:	\$	\$
Increases/decreases requested Increases (with Evidence of Ins Decreases due to age Evidence of Insurability required Employee life Employee STD	if amount of cov Class 1	erage applied for Class 2	Sp Ba	oouse life asic group (pelow:	+	d
Increases/decreases requested Increases (with Evidence of Ins Decreases due to age Evidence of Insurability required Employee life Employee STD Employee LTD	if amount of cov Class 1 \$ \$	erage applied fo	Sp Ba Bu	oouse life asic group o uy-up group	pelow: critical illness p critical illness	\$ \$	\$
Increases/decreases requested Increases (with Evidence of Ins Decreases due to age Evidence of Insurability required Employee life Employee STD	if amount of cov Class 1 \$ \$	erage applied fo	Sp Ba Bu	oouse life asic group o uy-up group	pelow: critical illness p critical illness	\$ \$	\$
Increases/decreases requested Increases (with Evidence of Ins Decreases due to age Evidence of Insurability required Employee life Employee STD Employee LTD Special requests: Check be [W-2 Services Option (Pleas	if amount of cov Class 1 \$ \$ cox and attach signer choose one)	erage applied for Class 2 \$ \$ \$ \$ \$ \$ \$ \$ additional s	Sp Ba Bu heet or le	pouse life asic group of uy-up group tter, if custo	critical illness p critical illness om dating, face an	\$ shounts, etc. are des	\$
Increases/decreases requested Increases (with Evidence of Ins Decreases due to age Evidence of Insurability required Employee life Employee STD Employee LTD Special requests: Check be [W-2 Services Option (Pleas Option 1: Withhold state and	if amount of cov Class 1 \$ \$ ox and attach sig e choose one) d federal income	erage applied for Class 2 \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$	Sp. Sp. Ba Bu heet or le	pouse life asic group of ay-up group tter, if custon portion of	critical illness p critical illness om dating, face an	\$ shounts, etc. are des	\$
Increases/decreases requested Increases (with Evidence of Ins Decreases due to age Evidence of Insurability required Employee life Employee STD Employee LTD Special requests: Check be [W-2 Services Option (Pleas	if amount of cov Class 1 \$ \$ ox and attach signer choose one) If dederal income ancome taxes, and	crage applied for Class 2 \$ \$ \$ ned additional setaxes, and the entire employee's	Sp Ba Bu heet or le mployee's portion o	pouse life asic group of uy-up group tter, if custo portion of f FICA. App	critical illness p critical illness om dating, face an	\$ nounts, etc. are des	\$ sired.

[1-10]. COBRA/STATE CONTINUATION

Is your group subject to: COBRA □ N	lo ☐ Yes State Continu	ation \square N	o □ Yes		
Number of existing COBRA participants	Medical:	Dental:		Vision:	
How many in COBRA election period	Medical:	Dental:		Vision:	
Are any present or former employees/depender If yes, enter information below. Attach addition				□ No □ Yes	
	Qualifying event (e.g. termin	ation of	Qualifying	COBRA/State	Continuation
Name of applicant	employment, divorce, etc.)		event date	Start date	End date

[STD and LTD only: Are employe	r contribut	ions taxed	l in emplo	yee payo	:hecks?		No 🗆 Y	'es]			
Coverage Employer's contribution for:	[Medical	[Dental	[Vision	[Life	[Voluntary Life	[STD	[BUY UP STD	[LTD	BUY U	[Workplace P Voluntary Benefits	
Employee	%	%	%	%	%	%	%	%	%	%	\$
Employee/spouse	%	%	%	%	%	N/A	N/A	N/A	N/A	%	\$
Employee/child	%	%	%	%	%	N/A	N/A	N/A	N/A	%	\$
Family	%]	%]	%]	%]	%]	N/A]	N/A]	N/A]	N/A]	%]	\$
[*For medical plans, Humana reservith employer contributions greater [1-10]. PRIOR/CURRENT C.	er than 50°	% of a pla	n's deduc	tible to a	require new an employee	's spend	ing accour	nt.]			
			[Med		[Dental] [Life	[Visio	n	[STD	[LTD
Is this group transferring from an	other grou	p carrier?	□ No	□ Yes	□ No □ Ye	s \square N	o □ Yes	□No□] Yes] No □ Yes	□ No □ Yes
If yes, provide carrier name				_			_				
Proposed termination date]]]
[Dental only: Did prior dental co											
The Mark I I will a B											
[For Workplace Voluntary Ber [Disability income carrier [CI/Cancer carrier [T-10]. PRODUCT SELECTION your quote for the plan's name. Also	ON - To (complete t	his sectio	[[n, please	☐ Individual☐ Ind	l ☐ Gr l ☐ Gr Underw	oup Cov riting Requ	verage te uirement	rminations s (reorde]]
[Disability income carrier [CI/Cancer carrier	ON - To (complete t	his sectio	[[n, please	☐ Individual☐ Ind	l ☐ Gr l ☐ Gr Underw	oup Cov riting Requ	verage te uirement	rminations s (reorde	n date r AR-52347).]]
[Disability income carrier [CI/Cancer carrier] [1-10]. PRODUCT SELECTI your quote for the plan's name. Also [a-g]. MEDICAL PLANS	ON - To o	complete t	his sectio	[[n, please	☐ Individual☐ Ind	l □ Gr l □ Gr Underw Guide v	oup Coveriting Requestion	verage te uirement	rminations s (reorde	n date r AR-52347).]]
[Disability income carrier [CI/Cancer carrier] [1-10]. PRODUCT SELECTION your quote for the plan's name. Also [a-g]. MEDICAL PLANS Is this a SmartSuite selection?	ON - To o	complete t	his sectio	[[n, please	□ Individua □ Individua e refer to the nt Disclosure	Underw Guide v	oup Covriting Required with your a	verage te uirement	rminations s (reorde	n date r AR-52347).]]
[Disability income carrier [CI/Cancer carrier] [1-10]. PRODUCT SELECTION your quote for the plan's name. Also also also be supported by the plan's name. Also also also also also also also also a	ON - To o	complete t	his sectio	[[n, please	☐ Individual☐ Ind	☐ ☐ Gr ☐ ☐ Gr Underw • Guide v	oup Cov riting Requivith your a ion:	verage te uirement	rminations s (reorde	n date r AR-52347).]]
[Disability income carrier [CI/Cancer carrier] [1-10]. PRODUCT SELECTION your quote for the plan's name. Also also also be supported by the plan's name. Also be su	ON - To o	complete the Regula	his section tory Pre-e	n, please	☐ Individual☐ Ind	☐ ☐ Gr ☐ ☐ Gr Underw ☐ Guide v	oup Coveriting Requirements of the control of the c	verage te uirement gent, bro	rmination s (reorde sker, or p	n date r AR-52347).	Please refer to
[Disability income carrier [CI/Cancer carrier] [1-10]. PRODUCT SELECTION of the plan's name. Also selection? [a-g]. MEDICAL PLANS Is this a SmartSuite selection? Product specification: Product specification: Product specification: U Health Care Flexible Spending	ON - To one of the order of the	complete the Regular Yes ☐ Yes (FSA) Educt specified age of 19 fpaper (reference)	Depoision be conder GN	endent C	☐ Individual☐ Ind	□ □ Gr □ □ Gr Underw □ Guide v □ pecificat pecificat pecificat Spending □ nployee,	oup Covriting Requirements of the control of the co	verage te uirement gent, bro (FSD)	rmination s (reorde sker, or p	r AR-52347). roducer.	Please refer to
[Disability income carrier [CI/Cancer carrier] [1-10]. PRODUCT SELECTIVE your quote for the plan's name. Also support of the plan's	g Account the sheet or the last 90 ered by Meered by Mee	(FSA) oduct special that apattment facilitation at the dical expecial to the dical expectation at the dical expectation a	his section tory Pre-entification: To to be consorder GN on employed individual ply) cility cility cility inses in the nave surguated to a	endent C vered in 1-52422): ee and the al in a redusability	☐ Individual ☐ Individual ☐ Individual ☐ Individual ☐ Product s ☐	□ □ Gr □ Underw □ Guide v □ pecificat pecificat pecificat Spending □ nployee, oup carri depended	oup Cov riting Requivith your a ion: ion: g Account No Y dependen er insuring nt (spouse	(FSD) (es t name, s t the dep or child),	rmination s (reorde sker, or p Hea statemen endent. COBRA	r AR-52347). roducer. Ith Savings Art t of disability/ beneficiary, covers //es //es //es	Please refer to

AR-71012-EA-LG 20111114 3 Reorder# AR-52248-LG [11/2011]

* Member Status: E=Employee D=Dependent C=COBRA R=Retiree Class

[He	alth Que	stionnaire for gro	ups en	rolling [100)+] employee	es:	(check all that a	apply)			
1.	Has any e	mployee been unabl	le to wo	rk 10 or more	e consecutive (day	s in the past 12	! months	due to an illness or	injury?	□ No □ Yes
2.	ls any emp	oloyee presently not	perforn	ning his or he	r duties on a f	ull-	time basis due	to an illn	ess or injury?		□ No □ Yes
	beneficiarconfinwho ir	ot of your knowledge y, or individual withing ed at home, in a host nourred more than \$ as been advised wit	in their o spital, o 10,000	COBRA/State r in a treatme of medical ex	Continuation ent facility spenses in the	ele pa:	ction period: st 24 months		nt (spouse or child), (COBRA	□ No □ Yes □ No □ Yes □ No □ Yes
4.	To the bes	st of your knowledge within their COBRA	e, is thei /State C	re any employ Continuation 6	/ee, individual election period	in a wł	a retiree class, d ho received trea	lepender itment, h	nt (spouse or child), (lad treatment recom st 24 months for any	mended, or	eficiary, or had medication
		S or an AIDS-related nune system disorde		ex or other	□ No □ Ye	es	Diabetes kidneys, l		isease or disorder of ungs	the	□ No □ Yes
		phol or drug abuse c chological disorder	r deper	dence, or	□ No □ Ye	es			including, but not lin clerosis, or Muscular		□ No □ Yes
	• Can	cer or cancerous tur	mor		□ No □ Ye	25	Heart or	vascular	disease or stroke		□ No □ Yes
	• Org	an transplant (other	than co	rneal)	□ No □ Ye	25					
		ed yes to questions 2334), if necessary.		ve, please inc	dicate the ques	tio	on number and e	explanati	on. Attach additiona	l signed and	d dated sheets
Qu	estion #	Member Status*		Medical Co Diagnosis	ndition/		ate(s) of reatment	Medica Dosag	ation Name/ e	Past/Curr Treatmer	rent/Future nt
* M	ember Stati	us: E=Employee D	=Depend	dent C=COB	BRA/State Contir	nuat	tion R=Retiree	Class			
Has	your com	, ,	uring the						a renewal of medica	al coverage	refused?
Hav	e any med	lical benefits now, o	r within						er other than health able time period up		
a-g]. DEN1	TAL PLANS (all gr	oup size:	5)							
				Plan 1					Plan 2		
Pla	n name (as shown on your p	roposal)								

	Plan 1	Plan 2
Plan name (as shown on your proposal)		
Funding type	☐ Employer sponsored ☐ Voluntary	☐ Employer sponsored ☐ Voluntary
Coinsurance	In% / / Out% / /	In% / / Out% / /
Deductible	In \$ Out \$	In \$ Out \$
Annual maximum	\$	\$
Preventive services deductible options	☐ Apply deductible ☐ Waive deductible	☐ Apply deductible ☐ Waive deductible
Periodontic/Endodontic options	☐ Basic ☐ Major	☐ Basic ☐ Major
Composite fillings for molars	□ No □ Yes	□ No □ Yes
Implant coverage	□ No □ Yes	□ No □ Yes
Orthodontia options	☐ Child only: lifetime ortho max \$ ☐ Adult & child: lifetime ortho max \$	☐ Child only: lifetime ortho max \$ ☐ Adult & child: lifetime ortho max \$
Out of network reimbursement options	☐ Max allowable fee ☐ In-network fee schedule	☐ Max allowable fee ☐ In-network fee schedule
Oral Surgery Covered In Basic	□ No □ Yes	□ No □ Yes
Open Enrollment	□ No □ Yes	

[a-g]. LIFE	(all group sizes) - Please refer t	o your proposal	
			D only applicable to certain plans)	
1			Increment (if applicable) \$	valend
			lary, rounded to the next highest \$1,000. Indicate salar imes between the classes and 10 times between the lov	
	Class	Description	mies between the classes and 10 times between the 10th	Benefit Amount / Salary Factor
	L	Description		benefit Amount / Sulary Factor
	ll .			
	III			
	IV			
. .				
		` *	certain plans) □ 2 Year □ 3 Year	
Age	Keduct vou are a	ion (only available with only selecting Voluntary Life A	c ertain plans) Age Reduction, age reduction values between Basic Em _l	olovee and Voluntary Life must match.
	•	,		,
Basi			If yes, indicate volume amount \$20,000/\$5,000	□ \$10,000/2,500 □ \$5,000/\$1,000
Volu		ployee Life □ No □	Yes If yes, do you want to select AD&D? □ No when enrolled in Voluntary Life) □ No	☐ Yes ☐ Yes
		tion (only available with ulso selecting Basic Employee	certain plans) e Age Reduction, age reduction values between Basic En	mployee and Voluntary Life must match.]
[Port	tability of	coverage (Applicable to Volu	untary Life only)	
[a-g]. VISIO	ON PLANS (all group sizes)		
			Plan 1	Plan 2
Plan	name (a	s shown on your proposal)		
Visio	n Optio	ns (For groups 100+ with a cus	stom vision plan, please list the in-network benefit options be	low.)
Func	ding type		☐ Employer sponsored ☐ Voluntary	☐ Employer sponsored ☐ Voluntary
Exan	n / mater	ial copayment	/	/
Fram	ne allowa	nce		
Cont	tact lens	allowance		

Frequency

AR-71012-EA-LG 20111114 5 Reorder# AR-52248-LG [11/2011]

[a-q]. SHORT TERM DISABILITY (group sizes 10+) Attach additional signed and dated sheets (reorder GN-52336), if necessary. Name of Class 1 ☐ Contributory ☐ Non-contributory Funding type □ Voluntary □ 50% □ 60% □ 66.67% ☐ Other _____ ☐ Flat amount \$ ____ Benefit schedule (select one) ☐ Incremental amount \$ Weekly benefit minimum \$ Weekly benefit maximum \$ ☐ Base salary ☐ Average _____ months bonus ☐ Average months commission Earnings definition ☐ Other **Duration** weeks □ 13 □ 26 □ 52 ☐ Other Elimination period (accident/sickness) □ 1/8 □ 8/8 □ 15/15 □ 30/30 ☐ Other Pre-existing limitation □ 3/3/12 ☐ None □ Other Waiting period: current employees ☐ Eligible on date of employment ☐ Eligible after active employment for days Waiting period: rehired/new employees ☐ Eligible on date of employment ☐ Eligible after active employment for days ☐ 2 Years ☐ Other Rate guarantee ☐ 1 Year Name of Class 2 Funding type □ Contributory ☐ Non-contributory □ Voluntary □ 60% □ 66.67% ☐ Other ☐ Flat amount \$ Benefit schedule (select one) ☐ Incremental amount \$ Weekly benefit minimum \$ Weekly benefit maximum \$ ☐ Base salary ☐ Average _____ months bonus ☐ Average _____ months commission Earnings definition ☐ Other **Duration** weeks □ 13 □ 26 ☐ 52 ☐ Other Elimination period (accident/sickness) □ 1/8 □ 8/8 □ 15/15 □ 30/30 □ Other _ Pre-existing limitation ☐ None □ 3/3/12 ☐ Other Waiting period: current employees ☐ Eligible on date of employment ☐ Eligible after active employment for _ days Waiting period: rehired/new employees ☐ Eligible on date of employment ☐ Eligible after active employment for _ days Rate quarantee ☐ 1 Year ☐ 2 Years ☐ Other _ [a-g]. LONG TERM DISABILITY (group sizes 10+) Attach additional signed and dated sheets (reorder GN-52336), if necessary. Name of Class 1 Funding type ☐ Contributory ☐ Non-contributory ☐ Voluntary Benefit schedule (select one) □ 50% □ 60% □ 66.67% □ Other ☐ Incremental amount \$ □ \$100 or 10% of monthly salary Monthly benefit minimum ☐ Other \$ Monthly benefit maximum ☐ Base salary ☐ Average ____ ___ months bonus ☐ Average _____ months commission Earnings definition ☐ Other Duration ☐ 2 Years ☐ 5 Years ☐ SSNRA ☐ Other __ Elimination period Days: □ 30 □ 60 □ 90 □ 180 □ Other _ Definition of disability Year own occupation: \square 2 \square 3 ☐ to age 65 □ Other Pre-existing limitation □ 3/3/12 □ 6/6/12 □ 3/12 □ 6/12 ☐ Other Mental health and substance abuse ☐ 24-month outpatient ☐ 12-month outpatient ☐ Other ___ limitation Waiting period: current employees ☐ Eligible on date of employment ☐ Eligible after active employment for _ days Waiting period: rehired/new employees ☐ Eligible on date of employment ☐ Eligible after active employment for days Rate quarantee ☐ 1 Year ☐ 2 Years ☐ Other

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[a-g]. LONG TERM DISABILITY (group sizes 10+) (continued)

Name of Class 2	
Funding type	☐ Contributory ☐ Non-contributory ☐ Voluntary
Benefit schedule (select one)	□ 50% □ 60% □ 66.67% □ Other □ Incremental amount \$
Monthly benefit minimum	□ \$100 or 10% of monthly salary □ Other
Monthly benefit maximum	\$
Earnings definition	☐ Base salary ☐ Average months bonus ☐ Average months commission ☐ Other
Duration	□ 2 Years □ 5 Years □ SSNRA □ Other
Elimination period	Days: □ 30 □ 60 □ 90 □ 180 □ Other
Definition of disability	Year own occupation: □ 2 □ 3 □ to age 65 □ Other
Pre-existing limitation	□ 3/3/12 □ 6/6/12 □ 3/12 □ 6/12 □ Other
Mental health and substance abuse limitation	□ 24-month outpatient □ 12-month outpatient □ Other
Waiting period: current employees	☐ Eligible on date of employment ☐ Eligible after active employment for days
Waiting period: rehired/new employees	☐ Eligible on date of employment ☐ Eligible after active employment for days
Rate guarantee	☐ 1 Year ☐ 2 Years ☐ Other
Additional benefits : Please refer to your p GN-52336), if necessary.	roposal for additional benefits available with plan selected. Attach additional signed and dated sheets (reorder
Cost of living adjustment (3%)	□ No □ Yes If Yes, □ Lesser of 3% or 1/2 CPI □ Lesser of 6% or 1/2 CPI Select number of adjustments □ 5 □ 10
Activities of daily living	□ No □ Yes If Yes, Additional maximum amount □ 10% □ 20% □ 30% □ 40%
Business income protection	□ No □ Yes If Yes, □ 15% to \$2,500 □ 25% to \$5,000
Special conditions limitation	□ No □ Yes If Yes, □ None □ 12 months □ 24 months
Survivor income benefit	□ No □ Yes If Yes, □ 3 month gross lump sum □ 6 month gross lump sum
Infectious & contagious disease	□ No □ Yes If Yes, Waiting period: □ 6 months □ 12 months Earnings loss: □ 20% □ 40% Duration of benefits: □ 2 Years □ 3 Years □ 4 Years □ Duration of claim Benefits cease if earnings exceed: □ 80 % □ 60 %
Accidental dismemberment and loss of sight	□ No □ Yes If Yes, Loss occurs within: □ 90 Days □ 180 Days □ 365 Days
Extended earnings	□ No □ Yes If Yes, Qualification for benefit: □ Less than 60% of PDE □ Less than 80% of PDE □ Less than 100% of PDE □ Less than 80% of PDE □ Less than 100% of PDE □ Less
Pension contribution	□ No □ Yes
Medical premium supplemental	☐ No ☐ Yes If Yes, Duration of Benefits: ☐ 2 Years ☐ 3 Years ☐ 4 Years ☐ 5 Years ☐ Duration of claim

[a-q]. WORKPLACE VOLUNTARY BENEFITS (all group sizes) [**DISABILITY INCOME PLUS**] [☐ No ☐ Yes] [Plan design] [☐ Benefits are provided in conjunction with an HSA plan] [☐ Benefits will be offered in conjunction with an IRS-qualified pre-tax plan] [Benefit period (select all that apply)] $[\Box [1-24]]$ Months $[\Box [1-24]]$ Months $[\Box [1-3] Years]$ $[\Box [1-3] \text{ Years}] [\Box [1-3] \text{ Years}]$ $[\Box [0-730]/[0-730]]$ $[\Box [0-730]/[0-730]]$ $[\Box [0-730]/[0-730]]$ $[\Box [0-730]/[0-730]]$ [Elimination period (select all that apply)] $[\Box [0-730] / [0-730]] \ [\Box [0-730] / [0-730]] \ [\Box [0-730] / [0-730]] \ [\Box [0-730] / [0-730]]$ [[0-730] / [0-730]] [Optional Benefits - Employer Selectable] [☐ Loss of work] [☐ 24-hour coverage] [□ Takeover] [Mental, nervous, alcohol and drug abuse] [Portability] ☐ Sickness elimination period waiver (available only if 7- or 14-day elimination period is selected for sickness)] [Optional Benefits - Employee Selectable] [☐ COBRA benefit] [Physical Therapy] $[\Box ICU/CCU]$ [Disability Income Advantage] [Base Benefit period (select all that apply)] $[\Box [1-24]$ Months] $[\Box [1-24]]$ Months $[\Box [1-3]]$ Years $[\Box [1-3]]$ Years [[1-3] Years] [Elimination period (select all that apply)] [[0-730] / [0-730]] $[\Box [0-730] / [0-730]] [\Box [0-730] / [0-730]]$ [[0-730] / [0-730]] [[0-730] / [0-730]] [[0-730] / [0-730]] $[\Box [0-730] / [0-730]] [\Box [0-730] / [0-730]]$ [[0-730] / [0-730]] [Optional Riders] [☐ 24-hour coverage] [Hospital confinement] [□ Takeover] [□ COBRA] ☐ Limited mental health/Emotional disease (only available with EP 0/14, 14/14, or 30/30)] [Income Protector (Non-Occ)] [Elimination period (select all that apply)] [[0-730] / [0-730]] [[0-730] / [0-730]] [[0-730] / [0-730]] [[0-730] / [0-730]] [[0-730] / [0-730]] [[0-730] / [0-730]] [[0-730] / [0-730]] $[\Box [0-730] / [0-730]]$ [[0-730] / [0-730]] [[1-24] Months] [Benefit period (select all that apply)] $[\Box [1-90] Days]$ $[\Box [1-2] \text{ Years}]$ $[\Box [1-2] \text{ Years}]$ [Optional Riders] ☐ Emergency Accident ☐ Outpatient Sickness ☐ Hospital Indemnity [☐ Group] [☐ Trust] [□ Individual] [Base Plan] \square Level 1] \square Level 2] \square Level 3] Benefits will be offered in conjunction with an IRS-qualified pre-tax plan [**Optional Riders**] [☐ Hospital Intensive Care (per day)] [[\$1-1,000] ☐ [\$1-1,000] ☐ [\$1-1,000] ☐ [\$1-1,000] ☐ [\$1-1,000] (May not be [Fracture and dislocation] $[\Box [\$1-1,000] \Box [\$1-1,000]$ [Accident total disability (elimination period)] available $[\Box [1-45] [Day(s)][Month(s)][Year(s)]]$ $[\Box [1-45] [Day(s)] [Month(s)] [Year(s)]$ $[\Box [1-45] [Dav(s)][Month(s)][Year(s)]] [\Box [1-45] [Dav(s)] [Month(s)] [Year(s)]$ with all plans.) ☐ On-the-job coverage ☐ Travel/Lodging $[\Box Loss of work]]$ [CRITICAL ILLNESS] [□ No □ Yes] [**Plan design**] [Benefits are provided in conjunction with a HSA plan] ☐ Benefits will be offered in conjunction with an IRS-qualified pre-tax plan ☐ Other critical illnesses [50 or] 100% of face amount] [Coverage choices] [□ Vascular] [□ Cancer] [Optional Benefits - Employer Selectable] [☐ Benefit recurrence] [☐ Loss of work] [☐ Takeover] [Optional Benefits - Employee Selectable] [Health screening benefit \$____ ___] [Automatic benefit increase]] [**Plan design**] [☐ Benefits offered in conjunction with an IRS-qualified pre-tax plan] [CRITICAL ILLNESS (Employer paid)] [Other group critical illness [50 or] 100% of face amount] [Coverage choices] [□ Vascular] [Cancer] [Optional Benefits - Employer Selectable] [☐ None] [☐ Benefit recurrence] [□ Takeover $[\Box$ Health screening:] $[\Box$ \$50] [\$100] [\$150] [\(\superstriangle \text{[\$1-500]}\) [☐ Loss of work] [☐ Class I Basic: \$ [Face amount (employee/member)] [☐ Class I Buy-up/Optional: \$ [☐ Class II Basic: \$_ [☐ Class II Buy-up/Optional: \$___ [☐ Spouse Basic: \$ % [☐ Buy-up/Optional: \$ or [Family options] or of employee/member amount] of employee/member amount] ___ or [☐ Child(ren) Basic: \$_ [☐ Buy-up/Optional: \$_ or

of employee/member amount]

[□ Basic: \$

[Maximum benefit amount]

of employee/member amount]

[☐ Buy-up/Optional: \$

[a-g]. WORKPLACE VOLUNTARY BENEFITS (continued)

[CRITICAL LIFE] [□ No □ Yes]		45] [Day(s)][Month(s)][Yea 45] [Day(s)][Month(s)][Yea)][Month(s)][Year(s)]])][Month(s)][Year(s)]]
[Optional Benefits - Employer Selectab	[□ Waiver of premium [□ Additional benefit i		ː] [□ Takeove living benefit - critical illn	er]
[CANCER] [☐ Cancer Expense] [☐ G [☐ Benefits will be offered in conjunction wi [Optional Riders - Cancer Expense] [Optional Riders - Cancer Lump Sum 10 [Optional Benefits - Group Lump Sum C	th an IRS-qualified pre-tax [Hospital indem -50] Lifetime pay] Cancer Employer selection	plan] nity] [□ Lump sum first dia [□ 20 Pay] able] [□ Benefit recurrence	agnosis] [□ Return of premi e] [□ Loss of work] ing \$]	-
[WHOLE LIFE] [☐ Whole Life 65] [Optional Riders] [☐ Waiver of premium [☐ Employee Term to J		[□ Whole ss of work] [□ Automa		□ Family Term]
[HEALTH CARE PLUS] [Hospital Confine □ Benefits will be offered in conjunction wi [Optional Riders] □ Hospital Inder				
[SUPPLEMENTAL HEALTH] [☐ No☐ Yes]	[□ Benefits will be offer	ed in conjunction with an I	RS-qualified pre-tax plan]	
[Base plan]	[□ Plan A]	[□ Plan B]	[□ Plan C]	[□ Plan D]
[Hospital Indemnity] [Hospital First Occurrence]	[\$100/day] [\$250/day]	[\$200/day] [\$500/day]	[\$300/day] [\$500/day (days 1-2)] [\$750/day (days 3-4)]	[\$500/day] [\$500/day (days 1-2)] [\$1,000/day (days 3-4)]
[Optional benefits - Employer selectabl	el			
Emergency Room] [ICU/CCU/Burn Unit benefit]	[\$50/day (ER)] [\$40/day (urgent care)] [\$100/day]	[\$100/day (ER)] [\$80/day (urgent care)] [\$200/day]	[\$150/day (ER)] [\$120/day (urgent care)] [\$600/day]	[\$250/day (ER)] [\$200/day (urgent care)] [\$1,000/day]
•	**	- ,-	7.	, ,
[□ Surgical Schedule][□ Diagnostic, laboratory and x-ray]	[\$500] [\$25/test (hospital)] [\$20/test (doctor's office or clinic)]	[\$1,000] [\$25/test (hospital)] [\$20/test (doctor's office or clinic)]	[\$1,000] [\$50/test (hospital)] [\$40/test (doctor's office or clinic)]	[\$2,000] [\$75/test (hospital)] [\$60/test (doctor's office or clinic)]
[Outpatient office visit]	[\$25]	[\$50]	[\$75]	[\$100]
[Wellness]	[\$50]	[\$50]	[\$100]	[\$150]
[If multiple plans are selected and plan availa	ability is limited by class, p	lease list what class of emp	oloyees are eligible for each	ch plan.]

[1-10]. THE FOLLOWING APPLIES TO ALL COMPANIES AND PLANS EXCEPT WORKPLACE VOLUNTARY BENEFITS

The companies listed on this Employer Group Application (EGA), severally or collectively as the context may require, are referred to in this EGA as we, us, and our.

In accordance with Section 503 of ERISA, as claims administrator we have authority to make decisions consistent with the terms of the Policy or Certificate regarding (1) eligibility for coverage; (2) paying claims for benefits; (3) interpretation of Policy or Certificate provisions; and (4) resolution of factual questions relating to coverage and benefits.

You, the participating employer, policyholder, contractholder, or Certificate sponsor, intend to establish, sponsor, plan sponsor and endorse an employee benefit plan which will be governed by Employee Retirement Income Security Act of 1974 (ERISA). You are the ERISA plan administrator.

[1-10]. THE FOLLOWING APPLIES TO ALL COMPANIES AND PLANS

You agree to make available your records which we determine are relevant to this EGA and group coverage for inspection by the Trustee, Administrator, us, or our representative during your normal business hours.

If you fail to pay premium when due, coverage may be subject to termination as specified under the terms of the Policy or Certificate. You understand and agree that your coverage is renewed on a monthly basis subject to timely payment of premium. We reserve the right to change the premium rates on any premium due date, as permitted by applicable law. You will receive advance written notice.

For you to remain eligible for the Policy or Certificate, the eligibility,

underwriting, participation, and contribution requirements must be maintained, for each respective coverage.

Failure to maintain the plan eligibility, underwriting, participation and contribution requirements will terminate your coverage under the Policy or Certificate.

We have the right to use information provided by you and any employee, dependent or individual to determine whether this EGA will be accepted or declined and to establish appropriate premiums. We will not use any health-related information to decline coverage to an employee, dependent or individual if this EGA is accepted. We will administer this in a non-discriminatory manner.

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[1-10]. AGREEMENT AND SIGNATURE - Review your policy/certificate carefully

You the employer, policyholder, contract holder, or Certificate sponsor understand, agree, and represent: You have read this Employer/Group Application (EGA) and the information you provided is accurate and complete to the best of your knowledge and belief and can be substantiated by your business records. You have received and reviewed the quote and the applicable required regulatory information. Neither you nor the agent has the authority to waive a complete answer to any question, determine coverage or insurability, alter any contract, bind us by making any promise or representation, or waive any of our other rights or requirements. No waiver or change will bind us unless signed by an authorized officer of our company. For action to be taken on this EGA, the first month's estimated premium (which may include a monthly administrative fee) and fully completed enrollment information for all employees and dependents must be submitted with the EGA. Coverage is not in effect unless and until you receive written notification from us. You will provide the documentation requested by us which establishes that all eligibility, underwriting, and participation requirements of the plan are met. Providing incomplete, inaccurate, or untimely information may void, reduce, or increase past premium, or terminate an individual's coverage or the group's coverage. This EGA will form part of any contract or coverage issued. If this EGA is declined, we will return the premium deposit submitted with this application. The original version of this Agreement is in the English language.

Any person who knowingly presents a false or fraudulent claim for payment of loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Dated on:	(month, date, year) at			(city and state)	
By:(Employer printed name)	(Employer	signature)	(Ti	tle)	
For Workplace Voluntary Benefits - only necess			(**	,	
·		•			
By:(Plan sponsor printed name)	r signature)	(Ti	tle)		
1-10]. AGENT/BROKER/PRODUCER	INFORMATION				
1. Agency of Record (for commissions ar		2. Agent/Agency of Record (for split con	nmissions)	
Name (print or type)		Name (print or type)			
Tax ID/Social Security Number/Humana Agent	Number	Tax ID/Social Security Number/H	umana Agent	Number	
Commission split ☐ No ☐ Yes If yes, percentage: (to	otal should equal 100%)	Commission split \(\square\) No \(\square\) If yes, percentage:			
1. Writing Agent/Broker/Producer		2. Writing Agent/Broker/Pro	ducer		
Name (print or type)		Name (print or type)			
Social Security Number/Humana Agent Numbe	er	Social Security Number/Humana Agent Number			
Commission split	otal should equal 100%)	Commission split ☐ No ☐ Yes If yes, percentage: (total should equal 100%)			
General Agency (Complete only if agency	involved in sale)				
General agency information pertains to: \Box	Agency of Record	Writing Agent			
Name (print or type)		Tax ID/Humana Agent Number			
Address		City	State	ZIP code	
As the Writing Agent/Broker/Producer, I acknow order to fully and accurately represent the term These provisions are available to me and the er	rledge that I am responsibles and conditions of the plant player in the Regulatory P	e to meet with the employer subm ns and services of the offering or i re-enrollment Disclosure Guide or	nitting this Em nsuring entity other plan lite	ployer Group Application or one of its subsidiarie erature.	
Vriting Agent/Broker/Producer's Signature:					

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[2-99] Employer/Group Application - Arkansas



FOR GROUP COVERAGE ([2-99] ELIGIBLE EMPLOYEES)

Humana.com

The offering company(ies) listed below, severally or collectively, as the content may require, are referred to in the Small Group/Employer Application as "Humana".

[Medical plans insured or administered by Humana Insurance Company.] [Dental plans insured or administered by [HumanaDental Insurance Company] [or] [Humana Insurance Company] [or] [CompBenefits Insurance Company].] [Dental HMO plans offered by American Dental Providers of Arkansas, Inc.] [Vision plans insured or administered by [Humana Insurance Company] [or] [CompBenefits Insurance Company].] [[Group Critical Illness], [Short Term Disability], [Long Term Disability] [and] [Workplace Voluntary] plans insured by Kanawha Insurance Company.] [Life plans insured or administered by [Humana Insurance Company] [or] [Kanawha Insurance Company].]

[1-10]. EMPLOYER COMPANY INFORM	ATION:	Please type	or print clear	rly in black ir	nk Inte	rnal use onl	y Grou	o number:	
Full legal business name					,			Requested et	ffective date
Corporate/Situs location street address (P.O. Box n	ot allowe	d) City			State	ZIP code		County	
	□ Sole Pr □ Other (oprietorship explain))	Date co	mpany e	stablished	Feder	al Tax ID	
Nature of business/SIC code	Busir (ness phone)	number			Business far	x numb	er	
Do you have more than one location? $\ \square$ No	□ Ye	S							
Benefit Administrator/Management contact	name:								
Phone number ()	Fax numb (er)			E-	mail			
Management contact: Mother's maiden name (this will be used to gain access to the Employer S	elf-Service	e Center on	www.Hum	ana.com)					
Billing contact name:									
Billing address (N/A, if same as street address)				City				State	ZIP code
Phone number (Fax numb (er)			E-	·mail			
[Are separate divisions/classes required for billing attach an additional page. Each additional page m				If yes, ple	ease expl	ain. If additi	onal sp	ace is neede	d, please
[For Workplace Voluntary Benefits: Effective of	date of po	licy and du	e date of fir	rst premium	n will be	(month, day	, year) _	//_]
[1-10]. ELIGIBILITY REQUIREMENTS									
Number of employees on payroll An working at least the number of hours per week as i	employee ndicated	who is elig in the table	gible to app below.	ly for insur	ance is c	one who is a	ctively a	nt work on a	full-time basis
	[All	[Medical	[Dental	[Life	[Vision	[STD	[LTD	[Group Critical Illness	[Workplace Voluntary Benefits
A. Number of hours worked per week to be eligible (select between 20 and 40 hours)									
B. Number of employees in a probationary waiting period (do not include in the eligible count below in C)									
C. Total number of eligible employees]]]]]]]]]
As of the date of this application, list any employe necessary)	es curren	tly disabled	and not ac	tively at wo	ork: (atta	ch additiona	al signed	d and dated	pages, if
Probationary waiting period for eligible employees (if you prefer months, please select "Other" and sp	s: □ 0 d pecify the	ays number of	30 days months)	□ 60 da	ays [□ 90 days	□0	ther (specify)
Employee effective provision: [(On all plans, excep STD/LTD is immediate.)] [New	/ waiting	period	. ∫ □ Imn	nediately fo	llowing	cides with th probationary probationary	/ waitin	g period]	vision.

[1-10]. ELIGIBILITY REQU	IREMENT:	S (continued)						
Do you want to exclude a class of If yes, check class to exclude: (Op union In non-union In ho	otions vary by	y plan. Refer to the						
Employee Eligibility by Class According to Federal health care may result in a penalty. To avoid plan does not favor highly compo	reform, an e	lease review any c	lass-based benefit	s with your le				
Has this group been insured by H If yes, please provide prior group				□ Yes				
Is this a Collectively Bargained P Plan number	lan? □ N	lo □ Yes Na	me of Plan	(Assi	gned by Employ	er for use ir	n filing IRS form	5500)
Do you wish to offer Domestic Pa	artner covera	age? □ No	☐ Yes					
Retiree information For groups 26+, are you offering	coverage to	rotiroos?	y □ Voc If you	roquirod ago		Ainimum va	ars of service	
Tor groups 20+, are you oriening	Coverage to	All	Medical	<u> </u>	ntal	Vision	Life (if app	
Number of current retirees to be	o covered	All	ivieuicai	ре	IIIai	VISIOII	тие (п арр	olicable)
Does this company have any sub tax return? ☐ No ☐ Yes If yes.			ere any other asso	ciated entities	that are eligible	e to file a fe	deral or state co	mbined
Company name							Total emplo	oyees
[Short Term Disability,] [Long			-					
Effective dates for changes		s of coverage	Effective fir	st day of mo	onth following	j change	Other	
Increases/decreases due to char								
Increases/decreases requested by								
Increases (with Evidence of Insu	ırability) requ	uested by employe	e					
Decreases due to age	:f f		f	-4				
Evidence of Insurability required				nts below:				
E I CED	Class			52 1.91		Class 1	Class	2
Employee STD	\$	\$		oup critical illn			\$	
Employee LTD				roup critical il				
☐ Special requests: Check bo		9	sneet or letter, if	custom dating	, face amounts,	etc. are des	irea.	
[W-2 Services Option (Please□ Option 1: Withhold state and□ Option 2: Withhold federal in	federal inco	me taxes, and the						
A detailed description of the W-2 be performed in accordance with		' '	'				a mail. Such serv	∕ices will
[1-10]. COBRA/STATE COM	NTINUATI	ON		-				
Is your group subject to:	OBRA 🗆	No ☐ Yes	State Continu	ation \square N	o 🗆 Yes			
Number of existing COBRA parti	cipants	Medical:		Dental:		Vision:		
How many in COBRA election pe	eriod	Medical:		Dental:		Vision:		
Are any present or former emplo If yes, enter information below. A						□ No [☐ Yes	
, , , , , , , , , , , , , , , , , , , ,						COBRA	/State Continu	uation
Name of applicant		employment,	ent (e.g. termin divorce, etc.)	ativii Vi	Qualifying event date	Start d		date
manic or applicant		emproyment,	aivoice, etc.)		event date	Start u	LIIU	

(STD and LTD only) Are employer	contributio	ns taxed in e	mployee's pay	check? 🗆 N	No [□ Yes]					
Coverage - Employer's contribution for:	[Medica	l [Dental	[Vision	[Life		luntary Life	[ST	D	[LTD	[Workplace Voluntary Benefits	e Spending Account*
Employee	%	6 %	%	%		%		%		% %	\$
Employee/spouse	%	6 %	%	%		%	N/A	4	N/A	%	\$
Employee/child	%	6 %	%	%		%	N/A	4	N/A	%	\$
Family	%] %]	%]	%]		%]	N/A	۱]	N/A]	%]	\$]
[* For medical plans, Humana re with employer contributions great									rwriting a	pproval or issui	ng coverage
[Life	I	Plan 1					Plan 2	2			
Employee											
Spouse											
Child(ren)]				
[1-10]. PRIOR/CURRENT C	ARRIER	INFORMA	TION								
			[Medical	[Denta	al	[Lif	e	[٧	ision	[STD	[LTD
Is this group transferring from ar	other grou	p carrier?	□ No □ Yes	□ No □	Yes	□ No □	⊒ Yes		o □ Yes	□ No □ Yes	□ No □ Yes
If yes, provide carrier name											
Proposed termination date]]]]]]
[Dental only: Did prior dental of											
[For Workplace Voluntary Be [Disability income carrier [CI/Cancer carrier					al 🛚	☐ Group				on date on date	
[(For Medical only)			Group's rene	wal date:							
	ployee \$		Spouse \$			Child(re	en) \$			Family \$	
Plan design	. ,		Office visit c	opay \$				r conf	inement o	copay \$	
Coinsurance In% Out	%		Deductible I	n%	Out	t	% Oı	ut-of-p	ocket In	% Out	:%
Emergency room copay \$			Prescription	drug benefi	t \$						
Renewal rates Em	ployee \$		Spouse \$			Child(r	en) \$			Family \$	
How many medical carriers have	you had in	the past five	years?]			-	-				
[1-10]. PRODUCT SELECTI your quote for the plan's name. A											Please refer t
[a-i]. MEDICAL PLANS	Dlan 1			Dlan 2					Dlan 2		
Plan name	Plan 1			Plan 2					Plan 3		

	Plan	1				Plan	2				Plan	3			
Plan name (as shown in your proposal)															
Office/Specialist copay (if applicable)	\$		/ \$			\$		/ \$			\$		/ \$		
Coinsurance	In		% / Out		%	In		% / Out		%	In		% / Out		%
Deductible	In \$		/ Out	\$		In \$		/ Out	\$		In \$		/ Out	\$	
Out-of-pocket limit	In \$		/ Out	\$		In \$		/ Out	\$		In \$		/ Out	\$	
Prescription drug/Retail card (Level 1 / 2 / 3 / 4)	\$	/\$	/\$	/	%	\$	/\$	/\$	/	%	\$	/\$	/\$	/	%
Prescription drug/Retail card - RxImpact (Group A / B / C / D)	\$	/\$	/\$	/\$		\$	/\$	/\$	/\$		\$	/\$	/\$	/\$	
Network name															

[a-i]. MEDICAL PLANS (continued)

Additional riders: Please refer to your proposal for rider availability with plan selected.

- Additional III	acis. Hease refer t	o your pro	7p03a1 101 1	iuci uvui	idollity with	piair sciec	icu.			I		
		Plan 1				Plan	2			Plan 3		
Deductible Ca	rryover Credit		□ No	☐ Yes			□ No	[□ Yes		0	☐ Yes
Supplemental	Accident		□No	☐ Yes			\square No	[□ Yes	□N	0	☐ Yes
[Employee Ass	sistance Program]		[□ No	☐ Yes]		[□ No	[□ Yes]	[۷o	☐ Yes]
Other:			□ No	☐ Yes			□No	[□ Yes		0	☐ Yes
Special Stat Optional Beha Benefit			□ No	□ Yes			□ No	[□ Yes	□N	0	□ Yes
	mpensation (ap o have 24-hour co):						' Comper	nsati	ion? □ No □	Yes		
[Health Que	stionnaire for g	roups e	nrolling	[2-99]	employee	s: (check	all that a	apply	y)			
	_	-	_						onths due to an illn	ess or injury?		□ No □ Yes
,	' '					•			n illness or injury?	, ,		□ No □ Yes
beneficiar	y, or individual wired at home, in a hacurred more than as been advised within their COBI	thin their nospital, conspiration \$10,000 vithin the dge, is the RA/State of hiatrist, p ed compleder e or deper tumor	COBRA/S or in a trea of medic elast 90 d ere any en Continuat ssychologi ex or othe ndence, o	state Co atment cal expe lays to h nployee, tion election election er	ntinuation facility nses in the nave surger individual ction perioc	past 24 r y or be ho in a retire who rec y practition	months ospitalized ee class, coeived trea oner within Diabetes kidneys, l Systemic Lupus, M	ed depe atme in th s or a liver dise	endent (spouse or cent, had treatment e past 24 months f any disease or disor or lungs ease including, but ble Sclerosis, or Mu	hild), COBRA recommended for any of the rder of the not limited to scular Dystrop	l, or follo	had medication
	ed yes to question 2334), if necessa					Г			anation. Attach add			
Question #	Member Status	s* Age	Medica Diagno		ition/	Date(s) Treatm			edication Name/ sage	Past/C Treatr		ent/Future t
								<u> </u>				
	. ,				State Contin							
	pany, at any time If yes, please ex		ie past 24 	month	s, had med	cal cover	age termi	inate	ed or a renewal of	medical cover	age	refused?
									manner other than applicable time peri			

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		Plan 1	Plan 2
Plan na	ame (as shown on your proposal)		
unding	g type	☐ Employer sponsored ☐ Voluntary	☐ Employer sponsored ☐ Voluntary
Coinsura	rance	In% / / Out% / /	In% / / Out% / /
Deductik	ible	In \$ Out \$	In \$ Out \$
\nnual r	maximum	\$	\$
reventi	tive services deductible options	☐ Apply deductible ☐ Waive deductible	☐ Apply deductible ☐ Waive deductible
eriodor	ntic/Endodontic options	☐ Basic ☐ Major	☐ Basic ☐ Major
Compos	site fillings for molars	□ No □ Yes	□ No □ Yes
mplant	t coverage	□ No □ Yes	□ No □ Yes
Orthodo	ontia options	☐ Child only: lifetime ortho max \$ ☐ Adult & child: lifetime ortho max \$	☐ Child only: lifetime ortho max \$ ☐ Adult & child: lifetime ortho max \$
Out of n	network reimbursement options	☐ Max allowable fee ☐ In-network fee schedule	☐ Max allowable fee ☐ In-network fee schedu
Oral Sur	rgery Covered In Basic	□ No □ Yes	□ No □ Yes
)pen En	nrollment	□ No □ Yes	
Basic Li Basic If yes Flat Sala Ma:	ic Employee Life	□ No □ Yes AD&D optional benefit riders: □ lary, rounded to the next highest \$1,000. Indicate sal	ary level: x salary
Basic Li Basic If yes Flat Sala Ma:	Life ic Employee Life	□ No □ Yes AD&D optional benefit riders: □	ary level: x salary owest and highest class (complete table below).
Basic Li Basic If yes Flat Sala Ma:	Life ic Employee Life □ No □ ss, do you want to select AD&D? at amount—indicate level: \$ lary plan—options are 1x to 7x sa aximum benefit \$	□ No □ Yes AD&D optional benefit riders: □ lary, rounded to the next highest \$1,000. Indicate sal	ary level: x salary
asic Li Basic If yes If yes Sala Ma. Cla II III	Life ic Employee Life	□ No □ Yes AD&D optional benefit riders: □ lary, rounded to the next highest \$1,000. Indicate sal	ary level: x salary owest and highest class (complete table below).
Basic Li Basic If yes If yes Sala Ma. Cla II III IV Rate Gu	Life ic Employee Life	□ No □ Yes AD&D optional benefit riders: □ lary, rounded to the next highest \$1,000. Indicate sal mes between the classes and 10 times between the l ar Schedule 1 Schedule 2 If yes, indicate volume amount Spouse \$	ary level: x salary owest and highest class (complete table below). Benefit Amount / Salary Factor Schedule 3

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Schedule 2 ___

Groups [2-99]: Included (Unless mandated by state)]]

Schedule 3 _____

Schedule 1_

[Rate Guarantee □ 2 Year □ 3 Year] [Age Reduction (Refer to your proposal)

[Portability of coverage (Applicable to Voluntary Life only)

[a-i]. VISION PLANS (all	group sizes)	
Plan name (as shown on your	proposal)	
[a-i]. SHORT TERM DISA	ABILITY (group sizes 2-9). Attach additional signed	I and dated sheets (reorder GN-52336), if necessary.
	Name of Class 1	Name of Class 2
Funding type	☐ Contributory ☐ Non-contributory	☐ Contributory ☐ Non-contributory
Benefit schedule (select one)	☐ 60% ☐ Flat amount \$	☐ 60% ☐ Flat amount \$
Weekly benefit minimum	\$25.00	\$25.00
Weekly benefit maximum	\$	\$
Earnings definition	■ Base Salary	■ Base Salary
Duration weeks	□ 13 □ 26	□ 13 □ 26
Elimination period (accident/sickness)	□ 1/8 □ 8/8 □ 15/15 □ 30/30	□ 1/8 □ 8/8 □ 15/15 □ 30/30
Pre-existing limitation	■ 3/12	■ 3/12
Waiting period: current employees	☐ Eligible on date of employment ☐ Eligible after active employment for days	☐ Eligible on date of employment ☐ Eligible after active employment for days
Waiting period: rehired/new employees	☐ Eligible on date of employment ☐ Eligible after active employment for days	☐ Eligible on date of employment ☐ Eligible after active employment for days
Rate guarantee	■ 2 Years	■ 2 Years
[a-i]. LONG TERM DISA	BILITY (group sizes 2-9). Attach additional signed a	and dated sheets (reorder GN-52336) if necessary
	Name of Class 1	Name of Class 2
Funding type	☐ Contributory ☐ Non-contributory	☐ Contributory ☐ Non-contributory
Benefit schedule (select one)	■ 60%	■ 60%
Monthly benefit minimum	■ Greater of \$100 or 10% of monthly income loss	■ Greater of \$100 or 10% of monthly income loss
Monthly benefit maximum	\$	\$
Duration	☐ 5 Years ☐ SSNRA	☐ 5 Years ☐ SSNRA
Elimination period	Days: □ 90 □ 180	Days: □ 90 □ 180
Definition of disability	Year own occupation: ■ 2	Year own occupation: ■ 2
Pre-existing limitation	■ 12/24	■ 12/24
Mental health and substance abuse limitation	■ 24-month outpatient	■ 24-month outpatient
Waiting period: current employees	☐ Eligible on date of employment ☐ Eligible after active employment for days	☐ Eligible on date of employment ☐ Eligible after active employment for days
Waiting period: rehired/new employees	☐ Eligible on date of employment ☐ Eligible after active employment for days	☐ Eligible on date of employment ☐ Eligible after active employment for days
Rate guarantee	■ 2 Years	■ 2 Years

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■ 3 month gross lump sum

■ 3 month gross lump sum

Survivor income benefit

[a-i]. SHORT TERM DISABILITY (group sizes 10+) Attach additional signed and dated sheets (reorder GN-52336), if necessary. Name of Class 1 ☐ Non-contributory □ Voluntary Funding type ☐ Contributory Benefit schedule (select one) □ 50% □ 60% □ 66.67% ☐ Other ☐ Flat amount \$ Weekly benefit minimum \$25.00 Weekly benefit maximum \$ ■ Base Salary Earnings definition **Duration** weeks □ 13 □ 26 □ 52 ☐ Other Elimination period (Accident/Sickness) □ 1/8 □ 8/8 □ 15/15 □ 30/30 ☐ Other Pre-existing limitation □ None □ 3/12 □ 6/12 ☐ Other Waiting period: current employees ☐ Eligible on date of employment ☐ Eligible after active employment for days ☐ Eligible on date of employment ☐ Eligible after active employment for Waiting period: rehired/new employees days Rate guarantee ☐ 1 Year ☐ 2 Years ☐ Other Name of Class 2 Funding type ☐ Contributory ☐ Non-contributory □ Voluntary Benefit schedule (select one) □ 50% □ 60% □ 66.67% ☐ Other ☐ Flat amount \$ Weekly benefit minimum \$25.00 Weekly benefit maximum \$ Earnings definition ■ Base Salary **Duration** weeks □ 13 □ 26 □ 52 ☐ Other Elimination period (Accident/Sickness) □ 8/8 □ 1/8 □ 15/15 □ 30/30 ☐ Other Pre-existing limitation □ None □ 3/12 □ 6/12 ☐ Other Waiting period: current employees ☐ Eligible on date of employment ☐ Eligible after active employment for days Waiting period: rehired/new employees ☐ Eligible on date of employment ☐ Eligible after active employment for days Rate quarantee □ 1 Year □ 2 Years □ Other [a-i]. LONG TERM DISABILITY (group sizes 10+) Attach additional signed and dated sheets (reorder GN-52336) if necessary. Name of Class 1 Funding type ☐ Contributory ☐ Non-contributory □ Voluntary □ 50% □ 60% □ 66.67% □ Other Benefit schedule (select one) Monthly benefit minimum ■ Greater of \$100 or 10% of Monthly Income Loss Monthly benefit maximum \$ Earnings definition ■ Base Salary Duration ☐ 2 Years ☐ 5 Years ☐ SSNRA ☐ Other Elimination period Days: □ 30 □ 60 □ 90 □ 180 ☐ Other ☐ to age 65 Definition of disability Year own occupation: \square 2 \square 3 ☐ Other Pre-existing limitation □ 3/3/12 □ 6/6/12 □ 12/12/24 □ 3/6/12 ☐ Other □ 6/6/24 Mental health and substance \square 24-month outpatient \square 12-month outpatient \square Other abuse limitation Waiting period: current employees ☐ Eligible on date of employment ☐ Eligible after active employment for days Waiting period: rehired/new employees ☐ Eligible on date of employment ☐ Eligible after active employment for days Rate guarantee ☐ 1 Year ☐ 2 Years ☐ Other

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[a-i]. LONG TERM DISABILITY (group sizes 10+) (continued)

Name of Class 2	
Funding type	☐ Contributory ☐ Non-contributory ☐ Voluntary
Benefit schedule (select one)	□ 50% □ 60% □ 66.67% □ Other
Monthly benefit minimum	■ Greater of \$100 or 10% of Monthly Income Loss
Monthly benefit maximum	\$
Earnings definition	■ Base Salary
Duration	□ 2 Years □ 5 Years □ SSNRA □ Other
Elimination period	Days: □ 30 □ 60 □ 90 □ 180 □ Other
Definition of disability	Year own occupation: ☐ 2 ☐ 3 ☐ to age 65 ☐ Other
Pre-existing limitation	□ 3/3/12 □ 6/6/12 □ 12/12/24 □ 3/6/12 □ 6/6/24 □ Other
Mental health and substance abuse limitation	☐ 24-month outpatient ☐ 12-month outpatient ☐ Other
Waiting period: Current employees	☐ Eligible on date of employment ☐ Eligible after active employment for days
Waiting period: Rehired/New employees	☐ Eligible on date of employment ☐ Eligible after active employment for days
Rate Guarantee	□ 1 Year □ 2 Years □ Other
Additional benefits : Please refer to your pr GN-52336), if necessary.	oposal for additional benefits available with plan selected. Attach additional signed and dated sheets (reorder
Cost of living adjustment (3%)	□ No □ Yes If Yes, ■ lesser of 3% or 1/2 CPI, select number of adjustments □ 5 □ 10
Activities of daily living	\square No \square Yes If Yes, select additional maximum amount \square 10% \square 20% \square 30% \square 40%
Business income protection	☐ No ☐ Yes If Yes, ■ 25% to \$5,000
Special conditions limitiation	□ No □ Yes If Yes, ■ 24 months
Survivor income benefit	☐ 3-month gross lump sum ☐ 6-month gross lump sum
[a-i]. WORKPLACE VOLUNTARY I	BENEFITS (all group sizes)
[DISABILITY INCOME PLUS] [No	☐ Yes] [Plan design] [☐ Benefits are provided in conjunction with an HSA plan] [☐ Benefits will be offered in conjunction with an IRS-qualified pre-tax plan]
[Benefit period (select all that apply)] [Elimination period (select all that apply)]	[☐ [1-24] Months]
[Optional Benefits - Employer Select	able] [☐ Loss of work] [☐ 24-hour coverage] [☐ Takeover] [☐ Mental, nervous, alcohol and drug abuse] [☐ Portability] [☐ Sickness elimination period waiver (available only if 7- or 14-day elimination period is selected for sickness)]
[Optional Benefits - Employee Select	rable] [□ COBRA benefit] [□ Physical Therapy] [□ ICU/CCU]
[Disability Income Advantage]	
[Base Benefit period (select all that apply) [Elimination period (select all that apply)	[
[Optional Riders]	[□ [0-730] / [0-730]] [□ 24-hour coverage] [□ Hospital confinement] [□ Takeover] [□ COBRA] [□ Limited mental health/Emotional disease (only available with EP 0/14, 14/14, or 30/30)]
[Income Protector (Non-Occ)] [Elimination period (select all that apply)] [[[0-730] / [0-730]] [[[0-730] / [0-730
[Benefit period (select all that apply)] [Optional Riders]	[[1-90] Days] [[1-24] Months] [[1-2] Years] [[1-2] Years] [Emergency Accident] [Outpatient Sickness] [Hospital Indemnity]

[a-i]. WORKPLACE VOLUNTARY BENEFITS (continued)

[ACCIDENT] [□ Group] [□ Trust] [□ Individual]		evel 1] [□ Level 2]	[□ Level 3] [□ Leve	el 4]
[Benefits will be offered in conjunction with an IRS-qu [Optional Riders] [Hospital Intensive Care (per day)		,000] 🗆 [\$1-1,000]	□ [\$1-1,000] □ [\$1-1	,000] 🗆 [\$1-1,000]
(May not be [Fracture and dislocation]		,000] [\$1-1,000]		/ \1 fa a
available \square Accident total disability (eliminat with all plans.)	ion period)] [□ [1-45] 1-45] □ [1-45]]	ear(s)]] [LL [1-45] [Dayl ear(s)]] [IL [1-45] [Dayl	(s)] [Month(s)] [Year(s)] (s)] [Month(s)] [Year(s)]
[On-the-job coverage] [Trave			car(3)]] [LL [1 43] [Day	(3/) [[[[[3/]]] [[[3/]]]
[CRITICAL ILLNESS] [No Yes] [Plan de			tion with a HSA plan]	
[□ Vascu			nction with an IRS-qual critical illnesses [50 or]	
[Optional Benefits - Employer Selectable] [Bene				100 /0 of face amount
[Optional Benefits - Employee Selectable] [Healt				
[CRITICAL LIFE] [□ No □ Yes] [Plan de		y(s)][Month(s)][Year(s)][Month(s)][Year(s)]]
 [Optional Benefits - Employer Selectable] [□ Waiv	الے [۱-45] الے er of premium]	y(s)][Month(s)][Year(s) [□ Loss of work]	[]] [□ [1-45] [Day(s) □ Takeove][Month(s)][Year(s)]] rl
[□ Addit	ional benefit increase] [Accelerated livi	ng benefit - critical illne	
[□ Accid	ental death and loss	of sight dismemberme	nt]	
[CANCER] [☐ Cancer Expense] [☐ Group Lump S [☐ Benefits will be offered in conjunction with an IRS-qu		ancer Lump Sum 10-5	50]	
		l Lump sum first diagr	nosis]	
[Optional Riders - Cancer Lump Sum 10-50] [L	ifetime pay] [□	20 Pay]	[□ Return of premiu	
Optional Benefits - Group Lump Sum Cancer Emp				☐ Takeover benefit]
[Optional Benefits - Group Lump Sum Cancer Emp	loyee selectable	☐ Automatic benef		
[WHOLE LIFE] [□ Whole Life 65] [□ Wh	ole Life 90]	☐ Whole Life	<u> </u>	
[☐ Whole the 65] [☐ William [☐ AD8] [☐ Employee Term to Age 65]			-] Family Term]
[HEALTH CARE PLUS] [Hospital Confinement Benefit	:] [□ \$250] [□ \$	500]		
☐ Benefits will be offered in conjunction with an IRS-qu		3 0 0 1		
[Optional Riders] [Hospital Indemnity]				
[SUPPLEMENTAL HEALTH] [☐ No☐ Yes] [☐ Benefit	s will be offered in co	njunction with an IRS	-qualified pre-tax plan]	
[Base plan]	[□ Plan A]	[□ Plan B]	[□ Plan C]	[□ Plan D]
[Hospital Indemnity]	[\$100/day] [\$250/day]	[\$200/day]	[\$300/day]	[\$500/day] [\$500/day (days 1-2)]
[Hospital First Occurrence]	[\$250/uay]	[\$500/day]	[\$750/day (days 3-4)]	
[Optional benefits - Employer selectable]	[450/1 /50)]	[#400/] (FD)]	, , , , , , , , , , , , , , , , , , , ,	, , , , ,
Emergency Room]	[\$50/day (ER)] [\$40/day (urgent	[\$100/day (ER)] [\$80/day (urgent	[\$150/day (ER)] [\$120/day (urgent	[\$250/day (ER)] [\$200/day (urgent
	care)]	care)]	care)]	care)]
[ICU/CCU/Burn Unit benefit]	[\$100/day]	[\$200/day]	[\$600/day]	[\$1,000/day]
[□ Surgical Schedule] [□ Diagnostic, laboratory and x-ray]	[\$500] [\$25/test (hospital)]	[\$1,000] [\$25/test (hospital)]	[\$1,000] [\$50/test (hospital)]	[\$2,000] [\$75/test (hospital)]
	[\$20/test (doctor's	[\$20/test (doctor's	[\$40/test (doctor's	[\$60/test (doctor's
□ Outpatient office visit]	office or clinic)] [\$25]	office or clinic)] [\$50]	office or clinic)] [\$75]	office or clinic)] [\$100]
[Wellness]	[\$50]	[\$50]	[\$100]	[\$150]
[If multiple plans are selected and plan availability is limit	ed by class, please lis	t what class of employ	ees are eligible for eac	h plan.]

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I1-10]. THE FOLLOWING APPLIES TO ALL COMPANIES AND PLANS EXCEPT WORKPLACE VOLUNTARY BENEFITS

The companies listed on this Employer Group Application (EGA), severally or collectively as the context may require, are referred to in this EGA as we, us, and our.

In accordance with Section 503 of ERISA, as claims administrator we have authority to make decisions consistent with the terms of the Policy or Certificate regarding (1) eligibility for coverage; (2) paying claims for benefits; (3) interpretation of Policy or Certificate provisions; and (4)

resolution of factual questions relating to coverage and benefits.

You, the participating employer, policyholder, contractholder, or Certificate sponsor, intend to establish, sponsor, plan sponsor and endorse an employee benefit plan which will be governed by Employee Retirement Income Security Act of 1974 (ERISA). You are the ERISA plan administrator.

[1-10]. THE FOLLOWING APPLIES TO ALL COMPANIES AND PLANS

You agree to make available your records which we determine are relevant to this EGA and group coverage for inspection by the Trustee, Administrator, us, or our representative during your normal business hours.

If you fail to pay premium when due, coverage may be subject to termination as specified under the terms of the Policy or Certificate. You understand and agree that your coverage is renewed on a monthly basis subject to timely payment of premium. We reserve the right to change the premium rates on any premium due date, as permitted by applicable law. You will receive advance written notice.

For you to remain eligible for the Policy or Certificate, the eligibility,

underwriting, participation, and contribution requirements must be maintained, for each respective coverage.

Failure to maintain the plan eligibility, underwriting, participation and contribution requirements will terminate your coverage under the Policy or Certificate.

We have the right to use information provided by you and any employee, dependent or individual to determine whether this EGA will be accepted or declined and to establish appropriate premiums. We will not use any health-related information to decline coverage to an employee, dependent or individual if this EGA is accepted. We will administer this in a non-discriminatory manner.

[1-10]. AGREEMENT AND SIGNATURE - Review your policy/certificate carefully

You the employer, policyholder, contract holder, or Certificate sponsor understand, agree and represent: You have read this Employer/Group Application (EGA) and the information you provided is accurate and complete to the best of your knowledge and belief and can be substantiated by your business records. You have received and reviewed the quote and the applicable required regulatory information. Neither you nor the agent has the authority to waive a complete answer to any question, determine coverage or insurability, alter any contract, bind us by making any promise or representation, or waive any of our other rights or requirements. No waiver or change will bind us unless signed by an authorized officer of our company. For action to be taken on this EGA, the first month's estimated premium (which may include a monthly administrative fee) and fully completed enrollment information for all employees and dependents must be submitted with the EGA. Coverage is not in effect unless and until you receive written notification from us. You will provide the documentation requested by us which establishes that all eligibility, underwriting, and participation requirements of the plan are met. Providing incomplete, inaccurate, or untimely information may void, reduce, or increase past premium, or terminate an individual's coverage or the group's coverage. This EGA will form part of any contract or coverage issued. If this EGA is declined, we will return the premium deposit submitted with this application. The original version of this Agreement is in the English language.

Any person who knowingly presents a false or fraudulent claim for payment of loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

If you decide not to sign this EGA, we will decline to enroll you in an insurance product or to give you insurance benefits.

Do NOT CANCEL ANY CURRENT GROUP COVERAGE UNTIL YOU RECEIVE WRITTEN NOTICE FROM US THAT WE HAVE ISSUED COVERAGE. Dated on: ______ (month, date, year) at _______ (city and state) By: ______ (Employer printed name) (Employer signature) (Title) For Workplace Voluntary Benefits - only necessary for non-employer groups. By: ______ (Plan sponsor printed name) (Plan sponsor signature) (Title)

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[1-10]. AGENT/BROKER/PRODUCER INFORMATION

1. Agency of Record (for commission	s and correspondence)	2. Agent/Agency of Record	(for split	commissions)			
Name (print or type)		Name (print or type)					
Tax ID/Social Security Number/Humana Aç	gent Number	Tax ID/Social Security Number/Humana Agent Number					
Commission split ☐ No ☐ Yes If yes, percentage:	(total should equal 100%)	Commission split \(\square\) No \(\square\) If yes, percentage:	Yes	(total should equal 100%)			
1. Writing Agent/Broker/Producer		2. Writing Agent/Broker/Pro	ducer				
Name (print or type)		Name (print or type)					
Social Security Number/Humana Agent Nu	ımber	Social Security Number/Humana	a Agent Nu	ımber			
Commission split ☐ No ☐ Yes If yes, percentage:	(total should equal 100%)	Commission split \(\square\) No \(\square\) If yes, percentage:	Yes	(total should equal 100%)			
General Agency (Complete only if ago	ency involved in sale)						
General agency information pertains to:	☐ Agency of Record ☐	Writing Agent					
Name (print or type)		Tax ID/Humana Agent Number					
Address		City	State	ZIP code			
As the Writing Agent/Broker/Producer, I ack order to fully and accurately represent the These provisions are available to me and th	terms and conditions of the pla	ns and services of the offering or	insuring er	ntity, or one of its subsidiaries			
Writing Agent/Broker/Producer's Signature:			Date:	:			

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Group Employee and Individual Application and Enrollment Form - [[2-99] Employees] [Arkansas]

The offering company(ies) listed below, severally or collectively, as the content may require, are referred to in the Group Employee and Individual Application and Enrollment Form "Humana". To elect primary care physician or dentist, please complete reorder AR-51340-PP.

[Medical plans insured or administered by Humana Insurance Company.] [Dental plans insured or administered] by [HumanaDental Insurance Company] [or] [Humana Insurance Company] [or] [CompBenefits Insurance Company].] [Dental HMO plans offered by American Dental Providers of Arkansas, Inc.] [Vision plans insured or administered by [Humana Insurance Company] [or] [CompBenefits Insurance Company].] [[Group Critical Illness], [Short Term Disability], [Long Term Disability] [and] [Workplace Voluntary] plans insured by Kanawha Insurance Company.] [Life plans insured or administered by [Humana Insurance Company] [or] [Kanawha Insurance Company].]

Please print c	learly and f	ill in e	ach app	olicable	circle.			Proposed	effect	ive date:	//
Employer / Group na	ame					Emp	loyer / Group	city			State
Qualifying Even O New business O New hire / New	enrollment]	C]	Open Enro	ving Event: Ilment ever einstatemer	nt] [dent birth c			ss of coverage] her]
Enrollment Info	ormation										
Relationship	Last name,	First na	ame MI	Height (ft / in)	Weight (lbs)	Gender	Full-time student?	Date of bi		and SSN within t	
Employee / Individual				1		O F O M	N/A	//			: (complete in Employee vidual Information section
Spouse / Domestic Partner				1		O F O M	N/A	//_		O N Reason SSN:	
Child / Dependent				1		O F O M	O N O Y	//_		ON Reason SSN:	
Child / Dependent				1		O F O M	O N O Y	//_		ON Reason SSN:	
Child / Dependent				1		O F O M	O N O Y	//_		ON Reason SSN:	
Other (specify):				1		O F O M	O N O Y	//		ON Reason SSN:	:
[If yes, please indi			[Hou	rs worked	d per we					_11	_]
SSN			51	treet address	State	ZIP co	nde		Phone	#()	APT / Suite / Bo
Language: O Engli	sh 🔾 Spanish 🔾	Other				l address			THORE	Occupation	
Employment status (o	check one)	O Active	• Retire	ee 🔾 COE	BRA					Annual salary \$	
Prior / Existing	f	rom Hui	mana of yo	our accepta	ance for co	overage.				tification	
[1-3]. [Prior medic						or other <u>c</u>	roup cover	age)? 〇 N 〇			
Frior medical insular	nce camer namej	[FOIICY #			ndividual or		oloyee / Indiv)] [۞ Family]	idual and spous	se]	Effective date	
[1-3]. [Other medic	cal coverage in	effect a									
[Other medical insura name]		[Policy #]	100 000	ner covera Employee / Ir	age type: ndividual or] nly] [۞ Em _[idual and spous	se] [E	Effective date / _	//]
[1-3]. [Medicare]		<u> </u>									
[Employee / Individua	al coverage: O N	[Y C	[Medicare II)		Eff	ective date _	_//	_	Term date	//]
[Spouse coverage: Q	NOY]		[Medicare II)		Eff	ective date _	_11	_	Term date	

1-2]. [Prior orthodontia coverage in the past [1-12]	months? O N O Y]	
Prior dental insurance carrier name	Policy #	[Prior coverage type:]
,	Effective date / /]	O [Employee / Individual only] O [Employee / Individual and spouse]
Prior carrier phone # ()]	Term date / /]	• [Employee / Individual and child(ren) • [Family]
overage Options		
Medical Group #:	Benefit #:	Class/Div:
Coverage type:] [O Employee / Individual only] [O Employee / Individual and child(r	mployee / Individual and spouse] en)] [• Family] [• No Coverage (complete waive	[Plan name:]
lealth Savings Account Group #:	Benefit #:	Class/Div:
lease refer to Humana's HSA contribution worksheet SAs on Humana.com. Select the Quick Link for Spen to you elect the Health Savings Account? [Beneficial ONOY (If no, complete waiver.)] information information in the complete waiver.	ding Account information on the Member page	ge. ividual's estate. You may change beneficiary
Coverage type:][O Employee / Individual only] [O Employee / Individual and spouse] [O Employee / Individual and child(re [O Family] [O No Coverage (complete waiver)]		nthly)]nthly)]
asic Life [/ AD&D] Group #:	Benefit #:	Class/Div:
Basic dependent life 🔾 N 🔾 Y (If no, complete wa	iver.)] [Class (employer	will provide you with this information, if needed)]
oluntary Life [/ AD&D] Group #:	Benefit #:	Class/Div:
Voluntary employee / individual [Amount fe coverage ○ N ○ Y] \$]	(min [\$1-unlimited])	
	11 11 11 11 11 11 11 11 11 11 11 11 11	raga?
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overage? O N O Y] \$] ision Group #: overage type:][O Employee / Individual only] [O Employee / Individual and spouse] [O Employee / Individual and child(ren	Benefit #: [Rate Amount \$ Rate Frequency (Mon [Rate Amount \$ Rate Frequency (Mon)] [Rate Amount \$ Rate Frequency (Mon [Rate Amount \$ Rate Frequency (Mon Benefit #:	Class/Div: thly)] [Plan name:] thly)] thly)] Class: Div:

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[O Accident] [ONOY]			O 1-6] [O 1-6] [O 1-6]	
	oyee / Individual only] [〇 Er	mployee / Individual and spouse]		
[O \$1-50,000][per d [O \$1-50,000][per d	ve Care Unit Benefits Rider day] [per month] [per year] day] [per month] [per year] day] [per month] [per year] day] [per month] [per year]		and Dislocation Benefits R [3 \$1-50,000]	ider]
O Optional Accident Total Disa	•	ion Benefit:][O \$1-50,000][O	[Days][Year] [O 1-120] [Mor	th][Days][Year]
Accident 2012	Group #:	Benefit #:	Class:	Div:
[O Accident] [O N O Y]		[Benefit Level:] [O 1-6] [O 1-6] [O 1-6]	O 1-6] [O 1-6] [O 1-6]
[Coverage type:] [O Emplo	oyee / Individual only] [O Er	mployee / Individual and spouse]	[O Employee / Individual ar	nd child(ren)] [O Family]
		[per year] [O \$1-1,000][per of [per year] [O \$1-1,000][per of [O \$		
Disability Income Plus	Group #:	Benefit #:	Class:	Div:
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[Base Benefit Period:]	[O 1-120][Month][Da [O 1-120][Month][Da	ith Waiver of Elimination Period ays][Year][ar][O 1-120] [Month][Day lays][Year] 0-500][O 0-500][/ 0-500]]
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[O Physic	O -500 O -500 C	CU Benefit [Class: C	Div: [Monthly Benefit \$] Div:
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[O Physic	O -500 O -500 C	CU Benefit] [\$1-2,000] [\$1-2 COBRA Rider]	Class: C	Div: [Monthly Benefit \$]

	AD&D] Group #:		efit #:	Class:	Div:
O Whole Life Child(ren)] [
			under the Enrollment I	nformation sect	tion of this application.]
ONOY Coverage on					Child 1 Benefit \$]
ONOY Coverage on C					Child 2 Benefit \$]
ONOY Coverage on	Child 3 Na	me			Child 3 Benefit \$]
Level Term Life	Group #:		efit #:	Class:	Div:
[O Level Term Life] [/ AD&D]	[Y O N O]	[Coverage type:]	[O Employee / Individual on [O Spouse] [O Child(ren)]		○10-Year Term] [○20-Year Term] nefit:] [○ Automatic Benefit Incre
[Employee / Individual Benefit \$]		[Spouse Benefit \$]		[Child(ren) Ben \$]	efit
a history of heart attacl [If yes, please indicate whet [•• You (Employee / Individ	k, heart disease, st ther this applies to yo lual)] [• Spouse] [•	croke, or cancer dia ou (Employee / Individ Dependent] [Name_	agnosis prior to age [1-dual), your spouse or a dep	100] ? • N • Ý endent.	
Term to 95	Group #:		efit #:	Class:	Div:
[O Term to 95] [O N O Y]			○ Employee / Individual only]		Children]
[Employee / Individual Benefit \$]		[Stand alone Spouse \$]		\$]	hild(ren) Benefit
Critical Illness	Group #:		efit #:	Class:	Div:
O Critical Illness	$[O\;N\;O\;Y]$	[Coverage type:]			oyee / Individual and spouse]
O Critical Illness and Can	cer] [ONOY]		O Employee / Individual	and child(ren)]	[Family]
[Optional Benefits:] [O A	utomatic Benefit Increa	se] [O Health Screeni	ng] [O Return on Premium]	[Employee / Inc	lividual Benefit \$]
Group Lump Sum Cance	·	Ben	efit #:	Class:	dividual), your spouse or a Div:
<u> </u>	er Group #:	Ben	efit #:	only] [O Empl	Div: oyee / Individual and spouse]
Group Lump Sum Cancer Group Lump Sum Cancer [Have you or any depen [If yes, please indicate when	Group #: [ONOY] Ident had a parent ther this applies to you	[Coverage type:] i, brother, or sister bu (Employee / Individual)	efit #: [only] [O Empland child(ren)] r diagnosis prid	Div: oyee / Individual and spouse] [O Family]
Group Lump Sum Cancer Group Lump Sum Cancer Have you or any depen If yes, please indicate wher You (Employee / Individ	Group #: [ONOY] Ident had a parent ther this applies to your limited with the control of the c	[Coverage type:] c, brother, or sister bu (Employee / Individed Dependent) [Name_	efit #: [only] [O Empland child(ren)] r diagnosis prid	Div: oyee / Individual and spouse] [O Family]
Group Lump Sum Cancer [○ Group Lump Sum Cancer]	Group #: [ONOY] Ident had a parent ther this applies to your thing applies to you the fit increase of th	[Coverage type:] i, brother, or sister bu (Employee / Individe Dependent] [Name_ ealth Screenings]	efit #: [only] [O Empland child(ren)] r diagnosis prid	Div: oyee / Individual and spouse] [O Family]
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Evidence of Health Status

This information should not be submitted more than [1-60] days prior to the effective date. [Complete this section for individuals, including dependents, enrolling or applying for [medical,][disability,] [life,] [or] [workplace voluntary] benefit coverage.]

[This section is required to be filled out for [Group Term Life,] [Long Term Disability,] [and] [Short Term Disability], if the following criteria applies:]

- [1-3.] [Over Guaranteed Issue Limit: Election of coverage exceeding the guaranteed issue amount (according to your policy) for which evidence of insurability is required.]
- [1-3.] [Opting up to Higher Level of Coverage: election of additional increments of coverage with insurance currently in force.]
- [1-3.] [Late Entrant: Employee who did not enroll during one of the following eligibility periods: initial eligibility date of hire or date of family status change, or during an annual enrollment and does not currently have coverage in force.]

	[1-7.] [Are you or any dependents currently taking any prescribed medication, or do you periodically take medication for a recurrent condition?					10	[Y C V
	[1-7.] [In the past [1-12] months, have you missed [1-5] or more consecutive days of work due to an injury or illness other than as a result of a cold, the flu, [back problems,] strained/sprained/fractured/broken limb or as a result of pregnancy?					ONOY]	
	[1-7.] [Have you or any dependent been diagnosed or received treatment for [an immune system disorder (i.e. Lupus, ITP),] AIDS or an AIDS-related complex?					ONOY]	
	[1-7.] [Within the past [1-5] years, have you or any eligible dependent to be covered been diagnosed with diseases or disorders related to, counseled, consulted, or treated by a doctor, including surgery, for any of the following:]						
	Coronary artery disease, chest pain, heart surgery, or any disease of the arteries, or blood disorders; anemia; o.] hemophilia; phlebitis; high blood pressure [(reading higher than 140/90)]?]	[a o.		or	O N
_	Nervous, mental or emotional disorder; convulsions; epilepsy; unconsciousness; Multiple Sclerosis; Parkinson's Disease; Cerebral Palsy?	O N]	[a o.] disorders:		
	[a- Stroke;Transient Ischemic Attack (TIA)? o.]	O N O Y	1	[a o.	Rheumatoid arthritis [; [or] back disorders; or joint disorders]?		ON]
	[a- emphysema; asthma, or other disease of lungs, or espiratory organs?	O N]	[a o.		ity?	
ᄓ	End stage renal disease; disease of kidney?O.]	O N O Y		[a o.			ON OY
	[a- Kidney stones; bladder? o.]	O N O Y]	0.			ON]
-	[a- Male or female organs; or infertility? o.]	O N -	$1^{ }$	[a o.	Alcoholism or drug habit?		ON OY
	[a- Cancer, and/or cancerous tumor[; including skin cancer]? o.]	O N	ĺ				
hospitalization, or surgery that has not been completed within the past [1-5] years?						[Y O <i>V</i>]	
[1-7.] [Within the past [1-5] years, has anyone enrolling or applying for coverage seen a health care provider or specialist for a routine physical/wellness exam, or been seen for any reason not previously disclosed?					10	[Y O <i>V</i>]	
[1-7.] [Are you or any dependent to be covered currently pregnant? If yes, please indicate anticipated delivery date below. [Anticipated delivery date:]					C	[Y O <i>V</i>]	

[If you answered "yes" to any of the questions above, please provide details below and specify the question #. Attach additional signed and dated sheets, (reorder AR-51340-MH), if necessary.

Question # & letter	Person treated (Last name, First name)		
Condition		Treatments received	
Medications prescribed		Current or future treatments or medications	
Date diagnosed / /		Date last seen by a doctor / /]	

Medical Health History

This information should not be submitted more than 60 days prior to the effective date. [Complete this section for individuals, including dependents, enrolling for medical, disability, life, or workplace voluntary benefit coverage.]

[1-6.] [Are you or any dependents to be covered currently pregnant? If yes, please indicate anticipated delivery date below. Anticipated delivery date:	ONOY]
[1-6.] [In the past [1-12] months, have you missed [1-5] or more consecutive days of work due to an injury or illness other than as a result of a cold, the flu [, back problems], strained/sprained/fractured/broken limb or as a result of pregnancy?	ONOY]
[1-6.] [Have you or any dependent been diagnosed or received treatment for an immune system disorder (i.e. Lupus, ITP), AIDS or an AIDS-related complex?	ONOY]
[1-6.] [Are you or any dependents currently taking any prescribed medication, or do you periodically take medication for a recurrent condition?	ONOY]
[1-6.] [During the last [1-24] months, have you or any dependents to be covered been diagnosed with, or treated for, any illness or injury or had surgery or hospitalization recommended?	ONOY]
[1-6.] [Within the past [1-12] months, have you or any dependents to be covered incurred medical expenses in excess of [\$1-100,000]?	ONOY]
If selecting life, please complete the following questions:	'
[1-4.] [In the past 5 years has any Proposed Insured been diagnosed, sought treatment, taken medication, or been hospitalized for any of the following: heart attack/heart surgery/heart disease, blood pressure readings above the normal range which have not been controlled with medication, stroke/transient ischemic attack (TIA), cancer (except basal cell skin cancer), end stage renal/kidney disease, diabetes (insulin dependent), alcohol and/or drug abuse, emphysema/lung disease, liver disease/ hepatitis/cirrhosis, neurological disorder/multiple sclerosis, lupus, blood disorder, or epilepsy?	ONOY]
[1-4.] [Had a parent, brother, or sister with a history of heart attack, heart disease, stroke, or cancer diagnosis prior to age [1-100]?	ONOY]
[1-4.] [Has any child proposed for coverage ever been diagnosed with or treated for congenital cardiac abnormality or other abnormalities, spina bifida, down's syndrome, cerebral palsy, or cystic fibrosis?	ONOY]
[1-4.] [Has any Proposed Insured been advised by a member of the medical profession to have any diagnostic test, hospitalization, or surgery that has not been completed within the past [1-5] years?	ONOY]
If you arewared "yos" to any of the questions above places provide details below and specify the question pu	ımbar Attach

[If you answered "yes" to any of the questions above, please provide details below and specify the question number. Attach additional signed and dated sheets (reorder AR-51340-MH), if necessary.]

Question #	Person treated (Last name, First name)		
Condition		Treatments received	
Medications prescribed		Current or future treatments or medications	
Date diagnosed / /		Date last seen by a doctor / /	

Waiver (refusal of coverage)

I acknowledge that I have been given the opportunity to apply for group coverage available to me and my dependents through my employer / group. I proclaim that I was not pressured or forced by my employer / group, the writing agent, or Humana into waiving (declining) coverage. If I have waived any coverage offered to me or my dependents, my signature is evidence of this action.

I hereby waive coverage for (che	ck all that app	oly):		I decline to apply for group coverage because of:
[Medical for:	O Myself	• My spouse	• My dependent child(ren)]	[O Spousal coverage]
[Dental for:	• Myself	• My spouse	• My dependent child(ren)]	[O Medicare supplement]
[Basic Life for:	• Myself	• My spouse	• My dependent child(ren)]	[O Individual coverage]
[Vision for:	Myself	• My spouse	• My dependent child(ren)]	O Coverage under another carrier's plan
[Short Term Disability for:	• Myself]			provided by my employer / group]
[Long Term Disability for:	• Myself]			O Other:
[Health Savings Account for:	• Myself]			
Waive Coverage for Workpla	ace Voluntar	y Benefits:		
[Whole Life for:	Myself		• My dependent child(ren)]	
[Level Term Life for:	Myself	• My spouse	• My dependent child(ren)]	
[Term to 95 for:	Myself	• My spouse	○ My dependent child(ren)]	
[Critical Illness for:	Myself	• My spouse	• My dependent child(ren)]	
[Group Lump Sum Cancer for:	Myself		• My dependent child(ren)]	
[Cancer Lump Sum 10-50 for:	Myself		• My dependent child(ren)]	
[Cancer Expense for:	Myself	• My spouse	• My dependent child(ren)]	
[Supplemental Health for:	Myself	• My spouse	• My dependent child(ren)]	
[Accident for:	Myself	• My spouse	• My dependent child(ren)]	
[Disability Income Plus for:	• Myself]			
[Disability Income Advantage for	: • Myself]			

Agreement

True and complete acknowledgement

I understand, agree, and represent:

- I have read the Group Employee and Individual Application and Enrollment Form or it has been read to me and answers provided are true and complete to the best of my knowledge and belief.
- Neither my employer / group nor the agent can waive any question, determine coverage or insurability, alter any contract or waive any of Humana's other rights and requirements.
- If the Group Employee and Individual Application and Enrollment Form for coverage is accepted, coverage will be effective on the date specified by Humana on the policy or certificate.
- If I have a new dependent as a result of a qualifying event, I may in the future be able to enroll myself or my dependents provided I request enrollment within [1-31] days after the qualifying event.
- If I or my dependents become eligible for premium or rate subsidies under Medicaid or the Children's Health Insurance Program (CHIP), I may in the future be able to enroll myself or my dependents provided I request enrollment within [1-60] days after the qualifying event. I understand eligibility for enrollment does not apply to a High Deductible Health Plan (HDHP).
- In the event that I should decide to apply for coverage hereafter, that subsequent Group Employee and Individual Application and Enrollment Form shall be subject to the applicable terms and conditions of the master group contract(s), policy provisions or certificate provisions which may require additional limitations and waiting periods.
- I may be required to furnish evidence of health status satisfactory to Humana.
- If I am declining coverage for myself or my dependents (including my spouse) because of coverage under Medicaid or CHIP, I may in the future be able to enroll myself or my dependents provided that I request enrollment within [1-60] days after my coverage under these programs ends. I understand eligibility for enrollment does not apply to an HDHP.
- If I am declining coverage for myself or my dependents (including my spouse) because of other coverage, I may in the future be able to enroll myself or my dependents provided that I request enrollment within [1-31] days after my other coverage ends.
- Humana reserves the right to delay medical coverage and/or deny life or dental coverage with any future submissions of the Group Employee and Individual Application and Enrollment Form for coverage.
- If any deductions are required for this coverage, I authorize those deductions from my earnings. If selecting the Health Savings Account (HSA), I authorize Humana or its banking partners to provide my account number to my employer / group for the purposes of depositing any contributions.
- If I am applying for coverage for my dependents (including my spouse) I attest by my signature below, I have gathered the necessary health information from my dependents in order to fully and truthfully complete the Group Employee and Individual Application and Enrollment Form.
- If I have selected workplace voluntary benefits, and if coverage is not issued as initially applied for, I hereby authorize Humana to decrease or increase the premium or rate amount stated on the Group Employee and Individual Application and Enrollment Form to cover the benefit actually issued.
- Any misrepresentation contained herein relied on by Humana may be used to reduce or deny claims or void the contract or coverage within the contestable period, if such misrepresentation materially affected the acceptance of the risk.
- Rates or premium quoted and the effective date requested are not guaranteed. The final rate or premium and effective date will be determined upon underwriting review and approval of the Group Employee and Individual Application and Enrollment Form by Humana.
- Any person who knowingly presents a false or fraudulent claim for payment of loss or benefit or knowingly presents false information in an application
 for insurance is guilty of a crime and may be subject to fines and confinement in prison.

If you decide not to sign this agreement, we will decline to enroll you in an insurance product or to give you insurance benefits.

Authorization

My dependents and I understand and agree:

• The information obtained by use of this authorization may be used by Humana to make claims determinations, determine eligibility for coverage, eligibility for benefits under an existing policy and plan administration.

• Any information obtained will not be released by Humana to any person or organization except to reinsuring companies, the Medical Information Bureau, Inc. or other persons or organizations performing health care operations or business or legal services in connection with the Group Employee and Individual Application and Enrollment Form, claim or as may be otherwise lawfully required, or as I (we) may further authorize.

Authorization for Release of Medical Records for Life or Disability

Signature - please sign below if enrolling or waiving group coverage.

If my dependents or I have selected life or disability, I authorize any third party to have information regarding myself. This includes any medical or non-medical information and to share any and all such information with Humana, its reinsurer or its legal representatives, and its affiliates. Once personal and health (including medical, dental, and pharmacy) information is disclosed pursuant to this authorization, the recipient may redisclose it and the information may not be protected by federal and state privacy requirements.

The Group Employee and Individual Application and Enrollment Form, together with any supplemental forms, will make up part of any contract and be the basis for any policy or certificate.

If you decide not to sign this authorization, Humana cannot complete your plan enrollment or determine your premium rate due

to the inability to obtain the necessary information. Employee / Individual or legal representative signature: Name and relationship of legal representative: Spouse signature: _____ (Only if selecting Life coverage over the guarantee issue amount.) **Agent / Producer Information** If applying for workplace voluntary benefits, this section to be completed by Agent or Producer. 1. Agent / Agency of Record: 2. Agent / Agency of Record: Name (print) Name (print) Humana Agent # Humana Agent # Commission split: Commission split: 1. Writing Agent / Producer: 2. Writing Agent / Producer: Name (print) Name (print) Humana Agent # Humana Agent # Commission split: Commission split: Will the coverage selected replace or change any existing life or disability insurance policy(s) and/or annuity(s)? O N O Y As the Writing Agent / Producer, I acknowledge that I am responsible to meet with the primary applicant submitting the Group Employee and Individual Application and Enrollment Form in order to fully and accurately represent the terms and conditions of the plans and services of the offering or insuring entity, or one of its subsidiaries. These provisions are available to me and the primary applicant in the benefit summary document or other plan literature.

The original version of this Agreement is in the English language. If there are any discrepancies or conflicts between the English and any other version that has been translated into another language, the English version will control.

County

Signed at _____

Writing Agent's Signature _____

State

Last name:	First name:
Large Group Employee and Individual Application and Enrollme	ent Form
The offering company(ies) listed below, severally or collectively, as the content may re and Individual Application and Enrollment Form as "Humana".	
[[Medical] [and] [Life] plans [insured] [or] [administered] by [Humana Insurance Company].] [HumanaDental Insurance Company] [or] [Humana Insurance Company] [or] [CompBenefits [American Dental Providers of Arkansas, Inc.]] [[Vision] plans [insured] [or] [administered] b Insurance Company].] [[Group Critical Illness], [Short Term Disability], [Long Term Disability] [Kanawha Insurance Company].]	Insurance Company].] [[Dental HMO] plans offered by by [Humana Insurance Company] [or] [CompBenefits
Print clearly and completely fill in each applicable circle.	
Employer / Group name Employer / G	roup city State
Qualifying Event Instructions	Office use only
	O Other]
[O New hire/Newly eligible] [O Rehire/Reinstatement] Qualifying event date (MM/DD/Y	YYYY) Benefit effective date (MM/DD/YYYY)
[O Dependent birth or adoption] [O Loss of coverage] / / / /	
Employee / Individual information	
- Last name First name	MI
Social security number Date of birth (MM/DD/YYYY)	Area code Phone number
Social security riumber Date of birth (Min/DD/11111)	()
Height (ft / in) Weight (lbs)	, , , , , , , , , , , , , , , , , , , ,
Street address	
Apt / Suite / PO box number	
Gender O Female O Male Language of choi	ice 🔾 English 🔾 Spanish
City State Zip co	ode County / Parish
E-mail address	
Employment status • Full-time employee / individual • Retiree • Cobra Date of full-time	e hire (MM/DD/YYYY)
Do you have a disability that affects your ability to communicate or read? •• No •• Yes •• Are you disabled or unable to perform reason:_	
Annual Salary Hours Worked per Week	
\$	
Occupation	
Primary care physician name Primary	y care physician ID # Current patient?
HMO/POSonly	O Yes O No
OBGYN Primary care physician name (if applicable) Primary	y care physician ID # Current patient?
HMO/POSonly	O Yes O No

D	ependent in	Formation Tournation	
Ente		each covered dependent, including spouse.	
1	Dependent last n	ame First name MI Gender O Female O Male	ļ
	Social security nu	mber Date of birth (MM/DD/YYYY) Relationship -	
	Height (ft / in)	Weight (lbs) Dependent status (if applicable): O Full-time student O Disabled	
	Not applicable	If disabled, indicate reason:	
	HMO/POS only	Primary care physician name Primary care physician ID # Current patient? Yes • No	
	HMO/POS only	OBGYN Primary care physician name (if applicable) Primary care physician ID # Current patient? Yes • No	
7	Dependent last na	me First name MI Gender	_
2		O Female O Male	
	Social security nur	nber Date of birth (MM/DD/YYYY) Relationship	
	-	- Spouse O Child O Other:	
	Height (ft / in)	Weight (lbs) Dependent status (if applicable): O Full-time student O Disabled If disabled, indicate reason:	
	Not applicable	or HumanaAccess HMO	
		Primary care physician name Primary care physician ID # Current patient?	
	HMO/POS only	O Yes O No	
	HMO/POS only	OBGYN Primary care physician name (if applicable) Primary care physician ID # Current patient? O Yes O No	
	Thivio/i O3 offiy	O TES O NO	_
3	Dependent last na		
		O Female O Male	
	Social security nur		
		- Spouse O Child O Other:	
	Height (ft / in)	Weight (lbs) Dependent status (if applicable): ○ Full-time student ○ Disabled	
	Not applicable:	or HumanaAccess HMO	
	ное аррисавіс	Primary care physician name Primary care physician ID # Current patient?	
	HMO/POS only	Trimary care physician name Trimary care physician by Current patient:	
	Time of the	OBGYN Primary care physician name (if applicable) Primary care physician ID # Current patient?	
	HMO/POS only	Obditivitimally care physician harmer (if applicable) Trimary care physician by Current patients:	
_	Dependent last n		_
4	Dependent last h	O Female O Male	د
	Social security nu		
	-	- Spouse O Child O Other:	
	Height (ft / in)	Weight (lbs)	
	/ / /	Dependent status (if applicable): O Full-time student O Disabled If disabled, indicate reason:	
	Not applicable	for HumanaAccess HMO	
		Primary care physician name Primary care physician ID # Current patient?	
	HMO/POS only	O Yes O No	
		OBGYN Primary care physician name (if applicable) Primary care physician ID # Current patient?	
	HMO/POS only	O Yes O No	

First name:

Last name:

		Last name:			First name:	
Use the followi	ng alternate address for	these dependents: Q	102030	O 4		
Street address	J · · · · · · · · · · · · · · · · · · ·					
Apt / Suite / PC) box number					
City			State	Zip code	County	
Medical						
[Coverage type	e:][O Employee / Individ	lual only]	Office use of	nly		
	[Employee / Individ		Group #	,,,,,	Benefit #	Class/Div #
	Employee / IndividFamily	uai & child(ren)]				
	O Other					
Plan name				N	etwork name	
					oouse's plan, another Hu	
	, .	list all: (This section n	nust be comple		to process any medical of	claims.)]
[Medicare ID	or medical carrier name:			[Medicare ID o	medical carrier name:	
	<u> </u>	Coverage Type				[Coverage Type
Starting dat	e (MM/DD/YYYY)	, (check all that app	oly)]	[Starting date (MM/DD/YYYY)	(check all that apply)
[End data if	applicable (MM/DD/VVVV)	[O Employee / I	ndividual]	[End data if an	plicable (MM/DD/YYYY)	[O Employee / Individual]
[Ella date, II	applicable (MM/DD/YYYY)	[O Spouse]] [O Child(ren)]		[Ellu date, ii ap		[Spouse]] [Child(ren)]
	<u> </u>					
	r any covered dependen lo] [If yes, list all: (This					in the past [1-18] months?
	al carrier name:	section must be comp	ieteu ioi riuilia	Prior medical (•	
[THO Incure	in currier righte.			[i noi medical c	arrier flame.	1
Starting dat	e (MM/DD/YYYY)	[Coverage Type		[Starting date (MM/DD/YYYY)	[Coverage Type
1		(check all that app	•		1	(check all that apply)]
[End date, if a	oplicable (MM/DD/YYYY)	[O Employee / I	Individual]	[End date, if app	icable (MM/DD/YYYY)	☐ ¹ [○ Employee / Individual] [○ Spouse]
/	/] [O Child(ren)]		/	1] [O Child(ren)]
Health S	avings Account (HSA) Applicable on	ly with High D	eductible Healt	h Plan selection	
Do you elect	the Health Savings Acc	ount?	Office use of			
	O No If no, complete v		Group #	лпу	Benefit #	Class/Div #
you may n	e medical coverage u ot be eligible for an l tax advisor for detail	HSA. Please check				
-			alculate vour r	navimum allowe	d contribution. You can	find additional information on

Please refer to Humana's HSA contribution worksheet to calculate your maximum allowed contribution. You can find additional information or HSAs on Humana.com. Select the Quick Link for Spending Account information on the member page.

Beneficiary for this account will be the employee / individual 's estate. You may change beneficiary information on file with the bank that administers the HSA once the account is established.

Last name:	First name:
Flexible Spending Account (FSA)	
Do you elect the flexible health account? O Yes O No If no, complete waiver section Annual amount elected: Office use only Group #	Benefit # Class/Div #
\$ SA HC	
Start date (MM/DD/YYYY) End date (MM/DD/YYYY)	
Do you elect the flexible dependent care account? O Yes O No If no, complete waiver section Group #	Benefit # Class/Div #
Annual amount elected: \$ \[\] , \[\] .00	
Start date (MM/DD/YYYY) End date (MM/DD/YYYY)	
Dental	
Office use only Group # Benefit #	Class/Div #
[Coverage Type] [and spouse] [O Employee / Individual and child(ren)]
Plan name	
[● Within the past [1-12] months, have you or any covered family individual had any a spouse's dental coverage? ○ Yes ○ No] [If yes, list all: (This section must be	completed for Humana to process any dental claims)]
[Orthodontia [Starting date coverage? (MM/DD/YYYY)	[End date, if applicable (MM/DD/YYYY)
]O Yes O No] /	
[Coverage Type (check all that apply)] [O Employee / Individual] [O Spouse] [O Ch	
[Orthodontia [Starting date [Prior dental carrier name: coverage? (MM/DD/YYYY)	[End date, if applicable (MM/DD/YYYY)
]O Yes O No] /	
[Coverage Type[/ee / Individual and spouse]
[Employee Primary care dentist name [D	entist ID # [Current patient?
[Employee Primary care dentist name]	[Dentist ID #] [Current patient?
[1 DHMO: DHMO:	O Yes O No]
[2 DHMO:	O Yes O No]
[3 DHMO:	O Yes O No]
Basic Life [/ AD&D]	
Office use only Group # Benefit #	Class/Div #
[Do you elect basic employee / individual life coverage? • Yes • No If no, com	plete waiver section]
[Class (employer / group will provide you with this information if needed) [Do you elect basic dependent life? • Yes • No If no, complete waiver section]]

		Last name:		First name:		
Voluntary	Life [/ AD&D]					
Office use on	lly Group #	В	enefit #		Class/Div #	
[Do you elect v	oluntary employee / ind	ividual life coverage?				
O Yes O No	[If no, complete waiver	r section]]				
[If yes, amount	elected (minimum of [\$	\$1-Unlimited:]) \$, .00]			
Voluntary de	pendent life selectio	n (available only if employee	e / individual elects v	oluntary life cove	erage):	
[Do you elect v	oluntary spouse life cov	rerage? • Yes • No If no, cor	nplete waiver section]			
[If yes, volunta	ry spouse life coverage ((minimum of [\$1-Unlimited:]):	\$,	.00		
[Do you elect v	oluntary child(ren) life c	coverage? • Yes • No If no,	complete waiver section	n]		
Vision						
Office use on	lly Group #	B	enefit #		Class/Div #	
[Covered individ	ual] [Individual only] [ee / Individual and spou	se] [O Employee	e / Individual ar	nd child(ren)]
Plan name						
Short Terr	m Disability					
Do you elect sl	nort term disability cove	erage? Office use only				
O Yes O No	If no, complete waiver		Benefit #	#	Class #	Div #
[Ruy-un nercen	t/amount					
	n Disability					
	ong term disability cover	rage? Office use only				
•	If no, complete waiver	Group #	Benefit #	#	Class #	Div #
	·					
Buy-up percent						
Group Te	rm Life [/ AD&D]					
Office use on	lly Group#	Bene	fit#	Class	#	Div#
Coverage requ	uested for (check all that		Coverage requested		Cost per pay	period
[Employee /	☐ Basic Term Life	(complete only if p	lan provides a choice of be	enefit schedules) \$.0
Individual]	Supplemental Terr			\$		0.
	Supplemental Ten	<u></u>		\$	<u> </u>	0.
	Supplemental AD			\$		0.
[Spouse]	Supplemental AD	αυ		\$		0.
[Spouse]	Supplemental Terr	m Life*		\$,	.0
	O Basic AD&D			\$.0
	O Supplemental AD	&D		\$.0
[Child(ren)]	O Basic Term Life			\$,	.0
	O Supplemental Terr	m Life*		\$,	.0
	O Basic AD&D			\$,	0.
	O Supplemental AD	&D		\$		0.
*Complete Evid	dence of Insurability forr	m if selecting one of these benefi	t amounts.			

Workplace Voluntary Benefits: Optional riders availability based on employer / group election. Accident Office use only Group # Benefit # Class # Div # Div # Class # Div #		Last name:	First name:
Office use only Group # Benefit # Class # Div # [O Accident] [O N O Y] Benefit Level:] [O 1-6]	Workplace Voluntary	Benefits: Optional riders availability based	on employer / group election.
[O Accident] [O N O Y] [Benefit Level:] [O 1-6] [O 1-6	Accident		
Coverage type: [Office use only Group #	Benefit #	Class # Div #
[O Samily] [O Optional Hospital Intensive Care Unit Benefits Rider] [O \$1-50,000] [per day][per month][per year] [O \$1-50,000] [O	O Accident] O N O Y	[Benefit Level:] [C) 1-6] [O 1-6] [O 1-6] [O 1-6] [O 1-6]
[O \$1-50,000] [per day][per month][per year] [O \$1-50,000] [O \$1-50,000] [O Optional Accident Total Disability Benefits Rider: Elimination Period] [O 1-120] [Month][Days][Year] [O 1-120] [Month][Days][ual and spouse] [O Employee / Individual and child(ren)]
Accident 2012 Office use only Group # Benefit # Class # Div # [O Accident] [O N O Y] [Benefit Level:] [O 1-6]	Optional Fracture and Dis	[O \$1-50,000] [[per day][per month][per year] [per day][per month][per year] [per day][per month][per year] [O \$1-50,000] O 1-120] [Month][Days][Year] [O 1-120] [Month][Days][Year] O 1-120] [Month][Days][Year] [O 1-120] [Month][Days][Year] O \$1-50,000] [O \$1-50,000] [O \$1-50,000]
Office use only Group # Benefit # Class # Div # [O Accident] [O N O Y] [Benefit Level:] [O 1-6] [O 1-	Accident 2012	, -	2
[Coverage type:] [O Employee / Individual only] [O Employee / Individual and spouse] [O Employee / Individual and child(ren)] [O Family] [O Pet Lodging] [O \$1-1,000][per day][per month][per year] [O \$1-1,000][per day][per month][per year] [O \$1-1,000][per day][per month][per year] Disability Income Plus		Benefit #	Class # Div #
[O Family] [O Pet Lodging] [O \$1-1,000][per day][per month][per year] [O \$1-1,000][per day][per month][per year] [O \$1-1,000][per day][per month][per year] [O \$1-1,000][per day][per month][per year] Disability Income Plus	[O Accident] [O N O Y]	[Benefit Level:]	[O 1-6] [O 1-6] [O 1-6] [O 1-6] [O 1-6] [O 1-6]
[O \$1-1,000][per day][per month][per year] [O \$1-1,000][per day][per month][per year] Disability Income Plus			al and spouse] [O Employee / Individual and child(ren)]
Office use only Group # Benefit # Class # Div #	Disability Income Pl	us	
	Office use only Group #	Benefit #	Class # Div #
[O Disability Income Covering Accident and Sickness][O N O Y] [Base Benefit Period:] [O 1-120] [Month][Days][Year] [O 1-120] [Month][Days][Year] [O 1-120] [Month][Days][Year] [O 1-120] [Month][Days][Year] [O 1-120] [Month][Days][Year] [Base Elimination Period:] [O 0-500][/ 0-500	[Base Benefit Period:]	[○ 1-120] [Month][Days][Year] [○ 1-120] [[○ 1-120] [Month][Days][Year] [○ 1-120] [d:] [○ 0-500][/ 0-500][○ 0-500][/ 0-500][○ 0	[Month][Days][Year] 0-500][/ 0-500][○ 0-500][/ 0-500]
[O Disability Income Covering Accident and Sickness with Waiver of Elimination Period] [O N O Y] [Base Benefit Period:] [O 1-120] [Month][Days][Year][O 1-120][Days][Year] \$ [Monthly Benefit		[○ 1-120] [Month][Days][Year][○ 1-120][D [○ 1-120] [Month][Days][Year] [○ 1-120] [Month][Days][Year]	Days][Year] \$.00]
[O 1-120] [Month][Days][Year] [Base Elimination Period:] [O 0-500][/ 0-500][/ 0-500] \$.00] [O 0-500][/ 0-500]][/ 0-500][/ 0-500] [Optional Disability Income Benefits: [O ICU/CCU Benefit] [O \$1-2,000] [O \$1-2,000] [O \$1-2,000] [O \$1-2,000] [O Physical Therapy Benefit]		d:] [○ 0-500][/ 0-500]]○ 0-500][/ 0-500] [○ 0-500][/ 0-500]]○ 0-500][/ 0-500] ome Benefits: [○ ICU/CCU Benefit] [○ \$1-2, [○ \$1-2,000] [○ \$1-2,000] [○	\$.000]

Last name:	First name:
Disability Income Advantage	
Office use only Group # Benefit #	Class # Div #
O Disability Income Advantage] O N O Y	
[Base Benefit Period:] [O 1-120] [Month][Days][Year] [O 1-120] [Month][Days	
[O 1-120] [Month][Days][Year] [O 1-120] [Month][Days [O 1-120] [Month][Days][Year] [O 1-120] [Month][Days][Year] [O 1-500][/ 0-50	\$ [COBRA Monthly Benefit .00]
Whole Life [/ AD&D]	
Office use only Group # Benefit #	Class # Div #
[O Whole Life] [/ AD&D] [O N O Y] [O Whole Life 99] [O Whole Life 90] [O Whole Life	E Life 65] [Employee / Individual Benefit \$.00] [Family Term Rider Spouse Benefit \$ Child(ren) Benefit \$]
Whole Life Spouse [/ AD&D]	
Office use only Group # Benefit #	Class # Div #
[O Whole Life Spouse] [/ AD&D] [O N O Y] [O Whole Life 99] [O Whole Life 90] [O N	
[○ AD&D Rider] [○ Automatic Premium Loan Option] [○ Family Term Rider (Child Coverage Only) Child(ren) Benefit Amount \$	\$, ,00]
Whole Life Child(ren) [/ AD&D]	
Office use only Group # Benefit #	Class # Div #
[O Whole Life Child(ren)] [/ AD&D] [O N O Y] [Child(ren) listed here must also be included as dependents under the Enrollment Information	on section of this application.]
O N O Y Coverage on Child 1 Child 1 Name O N O Y Coverage on Child 2 Child 2 Name O N O Y Coverage on Child 3 Child 3 Name	Child 2 Benefit \$]
Level Term Life	
Office use only Group # Benefit #	Class # Div #
[O Level Term Life] [O N O Y] [Coverage type:] [O Employee / Individual only] [C [Base Plan:][O 10 Year Term] [O 20 Year Term] [Optional Benefit:] [O Automatic Benefit Increase]	O Spouse] [O Child(ren)] [O No Coverage]
[Employee / Individual Benefit [Spouse Benefit	[Child(ren) Benefit
\$.00] \$.00] .00] [If your employer or group has elected the critical illness rider, have you or any with a history of heart attack, heart disease, stroke, or cancer diagnosis prior to [If yes, please indicate whether this applies to you (employee / individual), your spouse or a [O You (employee / individual)] [O Spouse] [O Dependent] [Name	o age [1-100]? O N O Y] dependent.
Term to 95	
Office use only Group # Benefit #	Class # Div #
[O Term to 95] [O N O Y] [Coverage type:] [O Employee / Individual only] [O Sp	pouse] [O Children] [O No Coverage]
[Employee / Individual Benefit [Stand alone Spouse Benefit \$.00] \$.00]	[Stand alone Child(ren) Benefit \$.00]

Last name:	First name:
Critical Illness Expense	
Office use only Group # Benefit #	Class # Div #
[O Critical Illness] [O N O Y] [Coverage type: [O Em	ployee / Individual only] [Employee / Individual and spouse] ployee / Individual and child(ren)] [Family]
[Optional Benefits:] [O Automatic Benefit Increase] [O Health Screening] [O Return on Premium]	[Employee / Individual Benefit \$.00]
[Have you or any dependent had a parent, brother, or sister with a hist diagnosis prior to age [1-100]? O N O Y] [If yes, please indicate whether the dependent. [O You (employee / individual) [O Spouse] [O Dependent] [Name]	
Group Lump Sum Cancer	
Office use only Group # Benefit #	Class # Div #
	ployee / Individual only] [Employee / Individual and spouse] ployee / Individual and child(ren)] [Family]
[Have you or any dependent had a parent, brother, or sister with a history of cance [If yes, please indicate whether this applies to you (employee / individual), your specific You (employee / individual)] [Spouse] [Dependent] [Name	
Rider: O Automatic Benefit Increase [O Health Screenings] [Benefit \$,
Cancer Lump Sum 10 - 50	
Office use only Group # Benefit #	Class # Div #
	ployee / Individual only] [
[O Em [Payment Period:] [O Lifetime] [O 5-80 years] Rider:] [O Return or	ployee / Individual and child(ren)] [O Family]
	Premium] [Base Benefit]
[O 5-80 years] [O 5-80 years]	001
	\$, .00]
Cancer Expense	
Cancer Expense Office use only Group # Benefit #	Class # Div #
Cancer Expense Office use only Group # Benefit # Coverage type: [O Em [O Em	
Cancer Expense Office use only Group # Benefit # Coverage type: [O Em	Class # Div # Div # ployee / Individual and spouse]
Cancer Expense Office use only Group # Benefit # [O Cancer Expense] [O N O Y] [Coverage type:] [O Em [Base Benefit \$	Class # Div # ployee / Individual and spouse] ployee / Individual and child(ren)] [Family]
Cancer Expense Office use only Group # Benefit # [O Cancer Expense] [O N O Y] [Coverage type:] [O Em [Base Benefit \$.00] [O Lump Sum Benefit (Equal to 50% of Base Benefit Amount)] [Rider:] [O Ho Supplemental Health	Class # Div # ployee / Individual only] [Employee / Individual and spouse] ployee / Individual and child(ren)] [Family] Div # ployee / Individual and spouse] ployee / Individual and spouse] Div # ployee / Individual and spouse] Div # ployee / Individual and spouse]
Cancer Expense Office use only Group # Benefit # Coverage type: O Em [O Em [Base Benefit]]	Class # Div
Cancer Expense Office use only Group # Benefit # Coverage type: [Class # Div
Cancer Expense Office use only Group # Benefit # Coverage type: [Class # Div
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Cancer Expense Office use only Group #	Class # Div
Cancer Expense Office use only Group #	Class # Div
Cancer Expense Office use only Group #	Class # Div # ployee / Individual and spouse] ployee / Individual and spouse] ployee / Individual and child(ren)] [

Last name:				First name:							
Evidence of Health Status											
This information should not be submitted more than [1 individuals, including dependents, enrolling or applying											
[[Long Term Disability] [and] [Short Term Disability] if th [1-3.] [Over Guaranteed Issue Limit: Election of coverage which evidence of insurability is required.] [1-3.] [Opting up to Higher Level of Coverage: election	je exceedi	ing th	e guaranteed	d issue amo						•	
[1-3.] [Late Entrant: Employee who did not enroll during date of family status change, or during an annual	g one of t	he fol	lowing eligib	oility period	ls: initi	al eligi	ibility	date			
[1-8.] [Within the past [1-12] months have you or, if applicable please indicate whether this answer applies to you (emplo	yee /individ	lual) or	your spouse C	Employee /	Individu	al OS	pouse				Y]
[1-8.] [Are you or any dependents currently taking any prescrib condition?										N O	
[1-8.] [In the past [1-12]months, have you missed [1-5] or more result of a cold, the flu[, back problems], strained/spraine	d/fractured	l/broke	n limb or as a	result of preg	nancy?					N Q	
[1-8.] [Have you or any dependent been diagnosed or received an AIDS-related complex?										N O	• Y]
[1-8.] [Within the past [1-5] years, have you or any eligible dep counseled, consulted, or treated by a doctor, including su	endent to k Irgery, for a	ny of t	ered been diag he following:]	nosed with d	iseases	or disor	rders re	elated	to,		
Coronary artery disease, chest pain, heart surgery, or any disease of the arteries or blood disorders; anemia; hemophilia; phlebitis; high blood pressure [(reading higher than 140/90 or above)]?		[a- o.]	Diabetes; liver enlargement of	r or thyroid d of the lymph	isease; ł nodes?	nepatiti	s; cirrho	osis; (or	0	N Y
Nervous, mental or emotional disorder; convulsions; epilepsy; unconsciousness; Multiple Sclerosis; Parkinson's Disease; Cerebral Palsy?	$\begin{bmatrix} O & N \\ O & Y \end{bmatrix}$	[a- o.]	Stomach, gall disorders?							0	N Y
Stroke; Transient Ischemic Attack (TIA)?	$\begin{bmatrix} 0 & \lambda \\ 0 & \lambda \end{bmatrix}$	[a- o.]	Rheumatoid a disorders]?							0	
Emphysema; asthma or other disease of lungs or respiratory organs?	$\begin{bmatrix} O & V \\ O & V \end{bmatrix}$	[a- o.]	Paralysis, or a				nt or de	formi	ity?	0	N Y
End stage renal disease; disease of kidney?	$\begin{bmatrix} 0 & \lambda \\ 0 & \lambda \end{bmatrix}$	[a- o.]	Chronic Fatigu	ue Syndrome <i>i</i>	/Fibromy	/algia?				0	N Y
[a- Kidney stones; bladder?	$\begin{bmatrix} 0 & 1 \\ 0 & 1 \end{bmatrix}$	[a- o.]	Diseases of th		se or th	roat?				0	
[a- Male or female organs; or infertility?	$\begin{bmatrix} 0 & N \\ 0 & Y \end{bmatrix}$	[a- 0.]	Alcoholism or	drug habit?						O	N Y
[a- Cancer, and/or cancerous tumor[; including skin cancer]? o] (state type & part of body in details section below)	S N]	1 6									
[1-8.] [Has any proposed Insured been advised by a member of hospitalization, or surgery that has not been completed v	within the p	oast [1-	-5] years?	, 3						O 1	
[1-8.] [Within the past [1-5] years, has anyone enrolling or app routine physical/wellness exam, or been seen for any real			-			cialist to	or a			O	
[1-8.] [Are you or any dependent to be covered pregnant? If ye [Anticipated delivery date:]	s, please in	dicate	anticipated de	livery date be	elow.) N	O	Y]
If you answered "yes" to any of the questions above, p Attach additional signed and dated sheets (reorder AR-				and specify	the q	uestio	n #.				
Question # & Letter (Person Treated) Last name			First n	ame							MI
Condition			Treatments	received							
			_								
Medications prescribed			Current or	future treatm	ents or	medica	ations			_	7
Date diagnosed (MM/DD/YYYY) Date last seen by a	doctor (MI	M/DD/	YYYY)								
] /										

I acknowledge that I have been given th				
				ana into waiving (declining) coverage. If I
have waived any coverage offered to me		idents, my signat	ure below is evidence of this acti	on.
I hereby waive coverage for (check all th	at apply):			I decline to apply for group coverage
[Medical for:	O Myself	O My spouse	• My dependent child(ren)]	because of:
[Dental for:	O Myself	O My spouse	• My dependent child(ren)]	[O Spousal coverage]
[Basic Life for:	O Myself	O My spouse	• My dependent child(ren)]	[O Medicare supplement]
[Voluntary Life for:	Myself	• My spouse	• My dependent child(ren)]	[O Individual coverage]
[Vision for:	O Myself	O My spouse	My dependent child(ren)]	O Coverage under another carrier's plan
[Group Term Life for:	• Myself]			provided by my employer / group]
[Short Term Disability for:	• Myself]			Other:
[Long Term Disability for:	• Myself]			1
[Health Savings Account for:	• Myself]			
[Flexible Health Account for:	• Myself]			
[Flexible Dependent Care Account for:	• Myself]			
Waive Coverage for Workplace Vol	•			
[Whole Life for:	O Myself	• My spouse	My dependent child(ren)]	
[Level Term Life for:	• Myself	O My spouse	• My dependent child(ren)]	
[Term to 95 for:	O Myself	O My spouse	• My dependent child(ren)]	
[Critical Illness Expense for:	O Myself	O My spouse	• My dependent child(ren)]	
[Group Lump Sum Cancer for:	O Myself	O My spouse	• My dependent child(ren)]	
[Cancer Lump Sum 10-50 for:	O Myself	O My spouse	My dependent child(ren)]	
[Cancer Expense for:	O Myself	• My spouse	• My dependent child(ren)]	
[Supplemental Health for:	• Myself	O My spouse	• My dependent child(ren)]	
[Accident for:	O Myself	O My spouse	My dependent child(ren)]	
[Disability Income Plus for:	O Myself]			
[Disability Income Advantage for:	O Myself]			

True and complete acknowledgement

I understand, agree, and represent:

 I have read the Large Group Employee and Individual Application and Enrollment Form or it has been read to me and answers provided are true and complete to the best of my knowledge and belief.

Last name:

Waiver (refusal of coverage)

- Neither my employer / group nor the agent can waive any question, determine coverage or insurability, alter any contract or waive any of Humana's other rights and requirements.
- If the Large Group Employee and Individual Application and Enrollment Form for coverage is accepted, coverage will be effective on the date specified by Humana on the policy or certificate of insurance.
- If I have a new dependent as a result of a qualifying event, I may in the future be able to enroll myself or my dependents provided I request enrollment with in [1-31] days after the qualifying event.
- In the event that I should decide to apply for coverage hereafter, that subsequent Large Group Employee and Individual Application and Enrollment Form shall be subject to the applicable terms and conditions of the master group contract(s), policy provisions or certificate provisions which may require additional limitations and waiting periods.
- I may be required to furnish evidence of health status satisfactory to Humana.
- If I am declining coverage for myself or my dependents (including my spouse) because of other coverage, I may in the future be able to enroll myself or my dependents provided that I request enrollment within [1-31] days after my other coverage ends.
- If I or my dependents becomes eligible for premium or rate subsidies under Medicaid or the Children's Health Insurance Program (CHIP), I may in the future be able to enroll myself or my dependents provided I request enrollment within [1-60] days after the qualifying event. I understand eligibility for enrollment does not apply to a High Deductible Health Plan (HDHP).
- If I am declining coverage for myself or my dependents (including my spouse) because of coverage under Medicaid or CHIP, I may in the future be able to enroll myself or my dependents provided that

I request enrollment within 60 days after my coverage under these programs ends. I understand eligibility for enrollment does not apply to an HDHP.

First name:

- Humana reserves the right to delay medical coverage and/or deny life or dental coverage with any future application for coverage.
- If any deductions are required for this coverage, I authorize those deductions from my earnings. If selecting the Health Savings Account (HSA), I authorize Humana or its banking partners to provide my account number to my employer / group for the purposes of depositing any contributions.
- If I am applying for coverage for my dependents (including my spouse) I attest by my signature below, I have gathered the necessary health information from my dependents in order to fully and truthfully complete the Large Group Employee and Individual Application and Enrollment Form.
- If I have selected workplace voluntary benefits, and if coverage is not issued as initially applied for, I hereby authorize Humana to decrease or increase the premium or rate amount stated on the Large Group Employee and Individual Application and Enrollment Form to cover the benefit actually issued.
- Any misrepresentation contained herein relied on by Humana may be used to reduce or deny claims or void the contract or coverage within the contestable period if such misrepresentation materially affected the acceptance of the risk.
- Any person who knowingly presents a false or fraudulent claim for payment of loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. If you decide not to sign this agreement, we will decline to enroll you in an insurance product or to give you insurance benefits.
- Rates or premium quoted and the effective date requested are not guaranteed. The final rate or premium and effective date will be determined upon underwriting review and approval of the Large Group Employee and Individual Application and Enrollment Form by Humana.

Authorization My dependents and I understand and agree: The information obtained by use of this authorization may be used by Humana to make claims determinations, determine eligibility for coverage, eligibility for benefits under an existing policy and plan administration. Any information obtained will not be released by Humana to any person or organization except to reinsuring companies, the Medical Information Bureau, Inc. or other persons or organizations performing Authorization for Release of Medical Records for Life or Disability If my dependents or I have selected life or disability, I authorize any third party to have information regarding myself. This includes any medical or non-medical information and to share any and all such information with Humana, its reinsurer or its legal representatives, and its affiliates. Once personal and health (including medical, dental and pharmacy) information
 The information obtained by use of this authorization may be used by Humana to make claims determinations, determine eligibility for coverage, eligibility for benefits under an existing policy and plan administration. Any information obtained will not be released by Humana to any person or organization except to reinsuring companies, the Medical Information Bureau, Inc. or other persons or organizations performing Authorization for Release of Medical Records for Life or Disability If my dependents or I have selected life or disability, I authorize any third party to have information regarding myself. This includes any medical or non-medical information and to share any and all such information with Humana, its reinsurer or its legal representatives, and its affiliates. Once personal and health (including medical, dental and pharmacy) information
health care operations or business or legal services in connection with this Large Group Employee and Individual Application and Enrollment Form, claim or as may be otherwise lawfully required, or as I (we) may further authorize. The Large Group Employee and Individual Application and Enrollment Form together with any supplements will form part
The Large Group Employee and Individual Application and Enrollment Form, together with any supplements, will form part of any contract and be the basis for any policy or certificate
Signature - Please sign below if enrolling or waiving any group coverage
Employee / Individual or legal representative signature Date / / / / / / / / / / / / / / / / / / /
Name and relationship of legal representative
(if a covered dependent) Agent / Producer Information If applying for workplace voluntary benefits, this section to be completed by Agent or Producer.
1. Agent / Agency of Record: 2. Agent / Agency of Record:
Name (print) Name (print)
Humana Agent # Humana Agent #
Commission split: Commission split:
1. Writing Agent / Producer: 2. Writing Agent / Producer:
Name (print) Name (print)
Humana Agent # Humana Agent #
Commission split: Commission split:
Will the coverage selected replace or change any existing life or disability insurance policy(s) and/or annuity(s)? O N O Y
As the Writing Agent / Producer, I acknowledge that I am responsible to meet with the primary applicant submitting the Large Group Employee and Individual Application and Enrollment Form in order to fully and accurately represent the terms and conditions of the plans and services of the offering or insuring entity, or one of its subsidiaries. These provisions are available to me and the primary applicant in the benefit summary docum or other plan literature.
Signed at County State

Writing Agent's Signature _____ Date ___/___/____

SERFF Tracking Number: HUMA-127883199 State: Arkansas
Filing Company: Humana Dental Insurance Company State Tracking Number: 50496

Company Tracking Number: AR-11-009

TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental

Product Name: AR App Maint - HDIC
Project Name/Number: Apps Update/PC-114

Supporting Document Schedules

Item Status: Status

Date:

Satisfied - Item: Flesch Certification Approved 12/20/2011

Comments: see attached

Attachment:

Catron-Certificate of Readability - AR-11-009.pdf

Item Status: Status

Date:

Bypassed - Item: Application Approved 12/20/2011

Bypass Reason: n/a

Comments:

Item Status: Status

Date:

Satisfied - Item: Statement of Variability Approved 12/20/2011

Comments: see attached Attachment:

Statement of Variability. Application.pdf

HUMANA DENTAL INSURANCE COMPANY CERTIFICATE OF READABILITY

Filing # AR-11-009

I hereby certify that these forms exceed the minimum reading ease score of 40 required by the State of Arkansas.

J. Gregory Catron Vice President Humana Dental Insurance Company



Statement of Variability for Application Forms

Bracketed Sections

- 1. Bracketed sections will refer to an entire portion of the form such as logos, product offerings, payment information, or agreements.
- 2. Bracketed sections are identified by green brackets.

NOTE: Some exceptions will apply due to state requirements or rulings regarding bracketing.

- 3. Non-bracketed logos, text, or numbers within the section remains constant and will not be subject to changes without being refiled.
- 4. Bracketed sections vary to the extent that such sections may be included, omitted or transferred to another page to suit the needs of a particular policyholder subject to any statutory or regulatory requirements.
 - For example: We have filed the Dental section of an application but the applicant did not select Dental then that section will not appear.
- 5. Bracketed variables such as logos, text, or numbers are subject to change as outlined within the various sections of this document.

Bracketed Numbers

- 1. With the exception of form numbers and matrix numbers, if allowed by the state, all bracketed numbers are variable.
 - Form numbers are located in the lower left-hand corner of the form and are not subject to change without refilling.
 - Reorder numbers (Group forms) and Revision numbers (Individual forms) are located in the lower right-hand corner of the form and are considered variable and included within this statement.
- 2. Bracketed numbers within a section are determined by the laws of the governing jurisdiction and will be varied only within the confines of the law.
- 3. Bracketed numbers will include the minimum and maximum ranges.
- 4. If the state determines ranges are not acceptable, only a single number will be shown on the form and that number will not be bracketed.

Bracketed Questions

- 1. Text within the bracketed question will not change (Refers to language only. See # 3 for formatting and placement changes).
- 2. Any bracketed variables within that question are subject to change.
- Bracketed questions vary only to the extent that such questions may be included, omitted or transferred within the form subject to any statutory or regulatory requirements.

Instructions or Help Text

- 1. Bracketed instructional text varies to the extent that such text may be included, omitted or transferred to another page to meet the needs of applicants completing the application.
- 2. Humana reserves the right to make minor instructional or help text revisions, even if it is not bracketed, as needed to clarify instructions for completion of the application and amend the language to clarify the intent within the confines of the law.

Product Information

- Product information may vary to the extent such information may be included, omitted, or transferred to another page subject to any statutory or regulatory requirements
- Additional fields within an existing product offering section can be added to an application without refiling for the purpose of offering new insurance products or benefits subject to
 - prior approval of certificate or policy forms for the new products or benefits;
 and,
 - any statutory or regulatory requirements

Legal Entities

- 1. New product or benefit plan designs or offerings that create a new or modify an existing legal entity will require filing.
- Legal entities will be bracketed when multiple entities are listed as insuring or administering entities. The applicable entity(s) will be shown based upon the applicant's/groups selection.
- 3. If there is only one legal entity listed as insuring or administering then it will not be bracketed

Demographic Information

Demographic information will not be bracketed but will fall under administrative changes which can be amended without refiling.

Administrative Changes and Clerical Errors

Humana reserves the right to amend the attached form(s) for any minor administrative changes or to fix clerical errors that may have unintentionally gone unnoticed prior to submitting for approval and to amend the language to clarify the intent within the confines of the law.

Forms are submitted in filing version format and are subject only to minor modification in paper size, stock, ink, border, and adaptation to computer printing. The application may be offered in a printed, on line, or digitized audio recorded format.